DOCUMENT RESUME

ED 280 228 EC 192 129

TITLE	Interagency Plan for Children with Special Needs.
INSTITUTION	Maryland Governor's Office for Children and Youth, Baltimore.; Maryland State Dept. of Education, Baltimore. Office of Special Education.; Maryland State Dept. of Health and Mental Hygiene, Baltimore.; Maryland State Dept. of Human Resources, Baltimore.
PUB DATE	Jan 86
NOTE	86p.; Portions of appendices contain small print.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Children; Clinical Diagnosis; Community Services; Delivery Systems; *Disabilities; *Human Services; Intervention; Prevention; Screening Tests; *State Agencies; *State Programs; *Statewide Planning
IDENTIFIERS	*Maryland

ABSTRACT

The Interagency Plan for Children with Special Needs for Maryland residents has three major purposes: (1) to set priorities for developing or expanding services required by special needs children and their families; (2) to ensure that resources targeted for special needs children are administered effectively by increasing interagency coordination in planning, financing, case managing, and administering services; and (3) to establish an action agenda for state administrators, the general assembly, advocates, parents, and provider agencies. This document presents the plan in two major sections. One section discusses the continuum of services for children with special needs involving five major areas: primary prevention activities; early intervention services; evaluation, assessment, and diagnostic services; in-home and community services; and substitute care services. A second section discusses interagency issues in managing the continuum of children's services and considers children not covered in the plan; ongoing long-range planning; service planning and case management; community education regarding the availability of services; coordinated interface with private sector providers; transitioning services; interagency licensing and monitoring; and interagency rate setting. Appendices present: definitions of handicapped children (as defined by the Maryland State Department of Education); service definitions; and descriptions of programs administered by the Department of Health and Mental Hygiene, the Department of Human Resources, and the State Department of Education. (CB)

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INTERAGENCY PLAN

for children with special needs

January, 1986

STATE OF MARYLAND

DEPARTMENT OF HUMAN RESOURCES DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MARYLAND STATE DEPARTMENT OF EDUCATION

Office for Children and Youth State Coordinating Council for Residential Placement of Handicapped Children

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INTERAGENCY PLAN FOR CHILDREN WITH SPECIAL NEEDS

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Governor's Children and Youth Initiative

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Mental Retardation and Developmental Disabilities Administration
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January 1986

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HARRY HUGHES
GOVERNOR

STATE OF MARYLAND
EXECUTIVE DEPARTMENT
ANNAPOLIS, MARYLAND 21404

January 27, 1986

The Honorable Ruth Massinga
Secretary
Department of Human Resources
1100 North Eutaw Street
Baltimore, Maryland 21201

Dear Secretary Massinga:

I am pleased to receive Maryland's Interagency Plan for Children with Special Needs which I requested as part of my Children and Youth Initiative. In my view the Plan and the recommendation for continued interagency coordination and planning represent a major step forward for agencies, providers, advocates and families in achieving the service system we all desire for these children. I want to emphasize my commitment to seeing that the recommendations and tasks set forth in the plan are implemented.

My thanks to you, Secretary Wilzack, Superintendent Hornbeck, and all other participants in the development of the Plan for producing this strong and useful document.

Sincerely,

Harry Hughes

Governor

PREFACE

Maryland's special needs children and their families often require the services of more than one State agency. Whether care is provided in the child's home, in school, in another community setting, or in a residential program, a child's full growth and development usually benefit from a continuum of health, social, and educational services.

Thus, if Maryland's special needs children are to be well served, State agency services must be well-coordinated. Collaboration is essential, not only for helping individual children, but for building the accessible, responsive services system sought alike by state and local government, private providers, advocates, and parents.

Within the past few years, a number of interagency efforts have contributed to children's well-being. The State Coordinating Council for the Residential Placement of Handicapped Children and its local counterparts are resolving some of the funding disputes of the past. The interagency budget and legislative agenda of the Governor's Children and Youth Initiatives of 1985, with support from the General Assembly, provided new resources for special needs children. In every local community, agencies share responsibilities for assisting children and families in need.

This Interagency Plan represents another major step toward achieving a comprehensive, coordinated service system for special needs children. We intend that it be the first of a series of annual plans in which State agencies set forth their short-term and longer-range goals and activities for helping children and their families. We also view this plan as part of an ongoing dialogue among State and local agencies, private providers, and advocates about how special needs children can best be served. For that reason, we welcome response and reaction to its recommendations.

Ruth Massinga,
Secretary,
Department of Human Resources

Adele Wilzack,
Secretary,
Department of Health and Mental Hygiene

David Hornbeck,
Maryland State Department of Education

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EXECUTIVE SUMMARY

Purpose of Plan

The Interagency Plan for Children with Special Needs was prepared at the direction of Governor Harry Hughes as part of the Children and Youth Initiatives of 1985. The Plan has three major purposes:

1. **To set priorities for developing or expanding services required by special needs children and their families;**
2. **To ensure that resources targeted for special needs children are administered effectively and efficiently by increasing interagency coordination in the planning, financing, case management, and administration of services;**
3. **To establish an agenda for action that can be useful to State administrators, the General Assembly, advocates, parents, and provider agencies as they gauge progress in meeting children's needs.**

The Plan was prepared collaboratively by the State agencies serving children, with participation and review by advocates and provider agency representatives. It covers a wide range of children with special needs including emotionally disturbed, developmentally disabled, and educationally handicapped children, as well as abused and neglected children, delinquent children, chemical abusers, and other special needs children. Originally, the plan was designed to focus more narrowly on children who require the services of many agencies in order to remain in their own homes and communities. However, it became clear that few — if any — individual agency services can be viewed apart from the services provided by other agencies because many children are likely to need assistance from more than one agency, either concurrently or at different times. For this reason, the plan was broadened to include the priorities of each agency for its own target populations, as well as those priorities agencies will pursue jointly.

Several principles of service underlie all of the recommendations included in the Plan:

- Services should be based on an individualized plan for each child which is appropriate to the child's needs in accordance with the child's age, developmental level, strengths, and weaknesses;
- Services should be delivered in the least restrictive setting appropriate to the child's needs;
- Services should involve the family to the greatest extent possible;
- Services should be focused on establishing a stable life situation for each child;
- Services should be accessible to all children with special needs and should be provided in a timely and flexible manner, allowing for transition among services and service agencies.

The agencies are committed to carrying out these principles as they expand, redeploy, and administer the services identified in the Plan.

The tasks identified in the Plan are both short-term and longer-range. Whenever possible, specific, quantifiable objectives for services are given (e.g., the development of a certain number of group home beds). For some services, however, the goals set forth here are more general; in the time available to produce the Plan, more detail was not possible. Even in these cases, however, agency responsibilities are assigned and timeframes established to ensure that follow-up planning will be done. The consensus among the participating agencies is that it is important to produce a baseline plan which can begin to guide budget and planning decisions for FY 1987 and FY 1988.

The recommendations and tasks of the Plan are organized into two major sections, reflecting the first two goals of the Plan above. One section identifies a continuum of care for Maryland's children with special needs and establishes priorities for development. A second section addresses interagency administrative, financing, and service delivery issues which must be addressed if the State's service system is to be effective.

Building a Continuum of Services for Special Needs Children

The Plan establishes a continuum of services which has five major areas: primary prevention activities; early intervention services; evaluation, diagnosis, and assessment services; in-home and community services; and substitute care services. Thirty specific services are identified within these categories.

The Plan's goals for building the continuum recognize that:

- Development of the "front end" of the continuum, i.e., primary prevention activities, has been slow. Carefully selected strategies for investing in prevention programs must be undertaken in order to prevent later problems for children.
- In-home and community resources are being developed by all agencies, but there is a particular need for interagency coordination among these services. The Plan gives priority to the development of alternative education programs, respite care, day care for children with special needs, parent aide services, and continued evaluation and development of intensive family services and family support programs which can prevent out-of-home care.
- In all areas of the continuum, mental health services for children are a priority for expansion, including: assessment/evaluation; community mental health care; therapeutic group homes; and specialized, short-term residential treatment. All state agencies serving children will have difficulty fulfilling their mandates if these services are not available.
- For future planning, priority is given to developing service and budget strategies for "uncovered children," i.e., those who receive inappropriate or no services. These include: emotionally disturbed children whose behavior is violent; dually diagnosed or multiply diagnosed youngsters; children whose behavior is socially unacceptable but who also have family problems; children who do not meet the criteria as educationally handicapped, but who nevertheless have severe problems in school; and handicapped youngsters who require long-term care, but whose parents cannot provide it.

The complete recommendations related to the continuum of care follow this Executive Summary.

Effective Management of Services for Children With Special Needs

This section of the plan identifies "cross-cutting" issues critical to the effective management of State agency services. Selected issues, and the recommendations made about them in the plan, include:

- **Service Planning and Case Management** Lead case management responsibility should be assigned for all special needs children receiving services from several agencies, based on interagency agreements that clarify agency responsibilities. Priorities for such interagency agreements are: between SSA and MHA for mental health services for foster children; and among SSA, MHA, and MRDDA for the joint development of specialized foster homes.

- **Community Education on Behalf of Special Needs Children** The Governor's Office for Children and Youth will identify a minimum base of services for special needs children to be available in each jurisdiction, and will coordinate a public education campaign to improve access to existing services.
- **Improved Interface with Private Sector Providers** Private sector representatives will have increased involvement in service planning. Public agencies are charged with clarifying service and funding priorities, policies toward purchase of care, and the need for program changes by specific providers.
- **Transitioning Services** MSDE will take the lead in coordinating agencies' plans for assisting children in their transition from a youth service system to independent living or adult services, and for promoting joint budgeting for transitioning activities as necessary.
- **Interagency Licensing and Monitoring** An interagency licensing workgroup will be established to work toward the goal of consistent minimum standards for all State-licensed children's facilities, with additional requirements developed for specialized types of facilities.
- **Interagency Rate Setting** Agencies will continue to develop a consistent approach to rate setting that reimburses as closely as possible the full, allowable costs of care, with clear cost guidelines for various services and with incentives for cost control.

Continuation of the Interagency Planning Process

Interagency planning and budgeting for special needs children should become an ongoing function of State government to ensure that services are focused on the whole child and to ensure an adequately funded continuum of care for special needs children.

An Interagency Planning Committee for Children (IPCC) will be established for this purpose. DHR will convene and chair this effort in FY 1987, as it did in FY 1986, at the Governor's request. Participating agencies will include JSA, ACA/DDA, MRDDA, and PMA from DHMH; MSDE; the Governor's Office for Children and Youth (OCY); and the State Coordinating Council (SCC); as well as advocates and provider representatives. The IPCC will monitor the implementation of the first Plan and develop or amend the Plan for future years, as required.

To ensure additional local input and advocacy representation in planning, the IPCC will expand its membership to increase representation from these groups. In addition, plans and proposals developed by the IPCC will be sent for review to local counterpart agencies.

All participants in the development of this first Interagency Plan for Children with Special Needs view it as only a first step in improving services for special needs children. However, through their commitment to the IPCC planning process, and, even more, through their commitment to implement the Plan, all participants believe that the tasks set forth in the Plan can yield improvements for Maryland's children with special needs and their families.

SUMMARY OF INTERAGENCY PLAN TASKS

I. Primary Prevention Activities

Objective – Strengthen the base of primary health care programs for children

TASK 1: DHMH, through the Medical Assistance Administration and in conjunction with the Preventive Medicine Administration, should continue to expand the EPSDT Program to ensure coverage of all income-eligible children in the State.

Objective – Develop a comprehensive statewide strategy for the prevention of children's disabilities

TASK 2: DHMH, through MRDDA, will prepare a three-year statewide plan focusing on prevention activities related to children's disabilities.

Objective – Expand program models which incorporate prevention-related activities along with direct treatment services

TASK 3: DHMH, through JSA, should develop a plan for the expansion of Youth Services Bureaus which provide community-based delinquency prevention services and daily supervised activities for teens.

II. Early Intervention Services

Objective – Expand mental health early intervention programs

TASK 1: DHMH, through the Mental Hygiene Administration, should expand mental health early intervention programs for children from birth to five years of age at risk of psychosocial and developmental dysfunction.

Objective – Enhance existing information and referral services available to special needs children

TASK 2: The Governor's Office for Children and Youth, in conjunction with the Maryland State Department of Education, the Department of Human Resources and the Department of Health and Mental Hygiene, should develop a plan to ensure that existing information and referral services reach the families of special needs children.

Objective – Evaluate and, as appropriate, expand services which strengthen parenting capacities and general family functioning

TASK 3: DHR, through SSA, will evaluate its pilot program of family support centers which is in its first year of pilot testing in FY 1986. If results of the ongoing evaluation are positive, SSA will plan to increase the size of this program in FY 1987 and FY 1988.

III. Evaluation, Assessment and Diagnosis Services

Objective – Reduce duplication in evaluation of the same children by establishing procedures by which agencies share information

TASK 1: Each State agency serving children (MSDE, SSA, JSA, PMA, MHA, MRDDA, ACA/DDA) and their local agencies should have within the agency standardized intake forms which are used consistently throughout the state.

TASK 2: MSDE (through local education agencies), SSA (through local departments of social services), JSA, MRDDA, ACA/DAA, and MHA should, to the extent permitted by law, make their written evaluations of specific children available and accessible to other State and local agencies involved in care planning for the child.

TASK 3: DHMH, through JSA, should develop comprehensive localized assessment capabilities for youth who are referred for substitute care through JSA.

IV. In-Home and Community Services

Objective – Expand community-based alternative education programs available to special needs children

TASK 1: MSDE, working with JSA, SSA, MRDDA, ACA/DAA, and MHA, will promote the development of appropriate alternative academic and vocational programs for youth who do not function well in regular education settings and who require a program of individualized instruction that meets their specialized needs.

Objective – Expand other home and community services whose absence creates the most severe gaps in the continuum

TASK 2: DHR, through SSA, and DHMH, through MRDDA, JSA and MHA, will develop an expansion plan for respite care, day care for special needs children, and personal care/parent aide services.

TASK 3: DHMH, through MHA, should expand treatment staff with specialties in child and adolescent mental health in community mental health centers and increase outreach services to emotionally disturbed children and their families, including home-based interventions.

TASK 4: In FY 1987 local mental health centers will enter into agreements with local departments of social services and locally-based JSA intake, probation and after-care units to make mental health consultation available.

Objective – Develop community-based service systems that better organize the diverse services needed to promote the growth and development of adolescents

TASK 5: DHMH, through JSA, should take the lead in developing a plan for the expansion of community-based programs for adolescents.

Objective – Expand community-based services which prevent entry into foster care and other forms of substitute care

TASK 6: DHR, through SSA, will continue to expand its family service programs in order to maintain children in their homes and communities rather than in foster care.

TASK 7: DHMH, through MRDDA, should expand the family support services program in the jurisdictions now participating as well as to the remaining uncovered jurisdictions in the State.

Objective – Establish a core service system to prevent adolescent pregnancy and to address the needs of teenage parents and their children

TASK 8: DHR, through SSA and local departments of social services, will coordinate development of a core services system to prevent teenage pregnancy and assist adolescent parents, as called for by the report of the Governor's Task Force on Teen Pregnancy.

Objective – Expand adoption opportunities for special needs children to ensure permanent homes for these children

TASK 9: DHR, through SSA and working in conjunction with MRDDA and the Developmental Disabilities Council, will explore adoption opportunities for special needs children with particular emphasis on minority children.

V. Substitute Care Services

Objective – Develop a wider range of residential care settings with emphasis on smaller, family-oriented and community-based settings

TASK 1: DHMH, through MRDDA, will continue to implement the FY 1985-1994 Master Facilities Plan for deinstitutionalization by:

a. reducing the number of State Residential Center beds by 37 percent (2,621 to 1,664 available beds); and

b. increasing the number of available community beds from 1,675 at the beginning of FY 1985 to 4,549 by the end of FY 1994

TASK 2: DHMH, through MHA, will establish four additional therapeutic group homes in FY 1986-1987 with a total capacity of 10 homes by FY 1988.

TASK 3: DHMH, through JSA, will investigate the development of two additional youth centers (one may be on the Eastern Shore) to ease overcrowding at Montrose and the Hickey School.

TASK 4: DHMH, through JSA, will seek to increase funding for placements in small residential settings.

Objective – Increase the availability of emergency shelter and assessment/diagnostic services for children, particularly those coming into foster care

TASK 5: DHR, through SSA, will seek to expand beds in emergency shelter care facilities or emergency foster homes, with associated diagnostic and assessment facilities, by approximately 40 beds in FY 1987 and FY 1988.

TASK 6: DHMH, through JSA, should expand from four to five the number of Runaway Youth programs which provide temporary emergency shelter care.

Objective – Expand the range of available types of foster family care, in order to better respond to the diverse needs of children coming into care

TASK 7: DHR, through SSA, will seek to expand the number of specialized or therapeutic foster homes to 60 beds by FY 1987.

TASK 8: DHR, through SSA, will take the lead with MRDDA and MHA in developing a multi-year strategy for more appropriate service for handicapped children requiring long-term care who are not appropriate for the current foster care system, and who have no other avenue for service.

Objective – Continue to develop in-state resources for children who now must be placed out-of-state because there is no appropriate Maryland facility which meets their needs

TASK 9: The State Coordinating Council for the Residential Placement of Handicapped Children (SCC) will identify common needs of out-of-state placements that could support alternative in-state programs.

Objective – Increase the range of specialized short-term residential services as necessary to meet the mental health needs of children

TASK 10: DHMH, through MHA, should — by August 31, 1986 — take the lead in developing a plan for bed expansion to accommodate the needs of emotionally disturbed children 12 years old and under with priority given to in-patient care, under 90 days.

TASK 11: DHMH, with JSA as the lead agency and with support from MHA and DHR/SSA, will develop a residential treatment program for children on the Eastern Shore.

INTRODUCTION

In 1986, of the estimated 1.16 million children under the age of 18 in Maryland, a significant number will have one or more chronic problems which impair normal functioning:

- An estimated 7.8 percent or 90,000 children annually will make use of special education services through local public schools.
- An estimated 11 percent or 127,600 children will require professional care to improve emotional or behavioral disturbances.
- An estimated 1 percent of the population or approximately 11,600 children are developmentally disabled or retarded and will need special education and support services to remain with their families.
- An estimated 37,000 children will come to the attention of the Juvenile Services Administration because of problem behavior or delinquency.
- Over 17,400 requests for protective services investigations for alleged child abuse and neglect will come to the attention of local departments of social services.
- More than 5,000 children will be in foster care because of the inability or unwillingness of their families to care for them.
- Over 33,500 children, or 10 percent of the population between the ages of 14 and 18, will experience problems with drugs or alcohol.

While many children may have multiple problems, and therefore the above numbers are not mutually exclusive, a substantial number of Maryland's children are at risk of out-of-home placements and need services to enable them to remain in their communities.[1]

To ensure that the State's response to these children is well-coordinated, Governor Hughes, as part of his Children and Youth Initiatives of 1985, requested the State agencies which serve children to prepare an Interagency Plan for Children with Special Needs. With the Department of Human Resources providing coordination, the development of the plan was collaborative, involving the several Administrations serving children within the Department of Health and Mental Hygiene, the Maryland State Department of Education, the Governor's Office for Children and Youth, and the State Coordinating Council for the Residential Placement of Handicapped Children. Advocate and provider agency representatives participated in the development of the Plan. The goals of the Plan, as detailed more fully on page 6, are to establish a continuum of services necessary for special needs children, and to ensure that the resources targeted for special needs children are administered effectively and efficiently.

As originally conceived the Plan was to focus on children with special needs who require the services of multiple state and local agencies to remain in their homes and communities. However, as the planning process evolved, it was evident in certain areas of service that the Plan had to go beyond the "multiple agency" agenda and identify the priorities which each agency was pursuing for its own target populations. Description and analysis of these priorities proved essential to establish the base for future cross-departmental planning. This interagency planning process for children, therefore, was used for agencies to put forth their own goals and priorities for children with special needs, as well as those essential cross-agency agendas both of which are a major part of this Plan.

[1]The age limits for State agency services differ by agency. While most agencies serve children up to age 18, others, including the Mental Retardation and Developmental Disabilities Administration, local education agencies and the Social Services Administration, provide services to persons through age 20.

The Plan contains three major sections:

- The first section (this section) describes the planning process, the State's system for serving special needs children and describes the special needs children covered under this Plan.
- The second section outlines a continuum of needed services, and agencies' plans for putting these services in place.
- The third section makes recommendations for resolving interagency administrative issues which affect the delivery of services.

The agencies which worked together to develop this plan view it as a first step in a continuing joint coordinated planning and budgeting process for special needs children. *To monitor the recommendations contained in this Plan and to continue the joint initiatives proposed, the agencies have established a permanent Interagency Planning Committee for Children (IPCC).* That committee is comprised of representatives of DHR/SSA, DHMH/JSA, DHMH/MHA, DHMH/ACA/DAA, DHMH/PMA, DHMH/MRDDA, MSDE, Office for Children and Youth, and the State Coordinating Council for the Residential Placement of Handicapped children. DHR/SSA will convene and chair the IPCC.

The IPCC will operate year-round for the following purposes:

- to monitor the implementation of the services and administrative recommendations contained in this Plan;
- to update the Plan annually, reflecting new joint planning and budgetary initiatives; and
- to provide information on the goals and priorities of the Plan to appropriate agency staff for use in budget development within and across agencies.

This ongoing planning is essential to ensure that the cross-departmental problem-solving represented by this Plan continues. A more complete description of the proposed interagency planning and budgeting process is included in the section on "Interagency Issues."

THE STATE AGENCY SERVICE SYSTEM FOR SPECIAL NEEDS CHILDREN

To serve special needs children, a network of state agencies and their local counterparts exists, with legal mandates for service outlined in federal and state statutes and regulations. The major State agencies and their areas of responsibility in relation to special needs children are:

Department of Human Resources (DHR)

Social Services Administration (SSA)

This is the agency with the primary responsibility for the provision of State child welfare services to children whose parents will not or cannot care for them. In addition, SSA makes available a range of other services to children and families in need. Specific services provided by the agency, primarily through local departments of social services, to special needs children include: protective services to children, foster care, adoption, in-home aide services, day care, single parent services, respite care, intensive family services, services to families with children and family support centers.

Department of Health and Mental Hygiene (DHMH)

The Mental Retardation and Developmental Disabilities Administration (MRDDA)

This agency is responsible for services to mentally retarded individuals and non-retarded developmentally disabled persons as well as the Crippled Children's Program. Services and programs in addition to the Crippled Children's Program include: family support services, individualized family placement/specialized family care, residential services, services coordination/case management, purchase of care, summer day programs, and state residential centers.

Alcoholism Control Administration (ACA)
Drug Abuse Administration (DAA)

The Alcoholism Control Administration and Drug Abuse Administration are responsible for establishing a comprehensive system of services aimed at the prevention of alcoholism and alcohol-related problems, and drug abuse and its related problems, and to provide treatment and rehabilitation services for those persons suffering from the effects of alcoholism, alcohol abuse and drug abuse. Within these administrations, treatment services for adolescents are a major priority. Programs include outpatient services, short-term residential treatment and a proposed new group home as well as general prevention programs within the public schools.

Juvenile Services Administration (JSA)

The Juvenile Services Administration has primary responsibility for providing services to troubled youth and their families in the area of delinquency prevention, treatment, and rehabilitation. The agency provides a broad range of rehabilitation services and promotes delinquency prevention through its community and institutional programs. Among its major services are youth service bureaus, clinical services, protective supervision, probation, after care, private residential placements, and detention and commitment institutions.

Mental Hygiene Administration (MHA)

This agency has primary responsibility for the treatment and rehabilitation of the mentally ill. Services provided to children and adolescents include mental health clinic programs, a special program to identify mental health problems in young children, in-patient psychiatric programs, therapeutic group homes, day treatment programs, and residential treatment centers.

Preventive Medicine Administration (PMA)

This agency provides technical and professional assistance and consultation to public and private agencies in relation to the prevention of disease, disability and health services. In relation to children, its mission is to ensure that all children of Maryland have access to a comprehensive system of quality child health services which emphasizes health promotion, disease and injury prevention, and early identification and remediation of handicapping conditions.

Maryland State Department of Education (MSDE)

The Maryland State Department of Education ensures the right to a free and appropriate public education for all educationally handicapped children from birth through the age of 20. Special educational services begin as soon as a child can benefit from them, regardless of age.

State Coordinating Council for Residential Placement of Handicapped Children (SCC)

This agency has the responsibility for approving or disapproving institutional placements for handicapped children, funding approved placements, and tracking residential placements. It is also responsible for developing a data base for program development purposes in order to serve handicapped children in community-based in-state care, rather than out-of-state institutional programs.

Governor's Office for Children and Youth (OCY)

This Office has the responsibility for examining programs, services, and plans for children under the age of 18. The purpose is to identify duplications or inefficiencies, analyze the effectiveness of programs, and identify resources and unmet needs. The office acts as a resource to the Governor, the General Assembly and the public on matters concerning children and youth.

In addition to these State agencies and their local counterparts which serve children, a wide array of private agencies provide services with financial support from State government, local government, and private sector sources. While the services of these agencies are not incorporated in this first-year plan, they represent an essential part of the State's service system for special needs children.

TRENDS AFFECTING THE STATE'S SERVICES TO SPECIAL NEEDS CHILDREN

Since the 1970's there have been numerous efforts both at the state and federal levels to establish and improve a broad range of services to special needs children and their families. On the federal level, the enactment of P.L. 94-142, the Education for All Handicapped Children Act of 1975, and P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, were landmark legislative efforts which profoundly influenced Maryland's programs and services to special needs children.

However, even prior to the enactment of these laws, Maryland's efforts to serve special needs children were substantial. Early activities focused on the educational system: in 1973 the General Assembly mandated free educational programs for all handicapped children. This was followed by a State Circuit Court Decree, issued by Judge John Raine in 1974, which stated that no child could be excluded from educational services and, when referral to private institutions was made, the cost was to be the responsibility of public authorities. The late 1970's saw the completion of the work of two gubernatorial-appointed Commissions (the Shifter Commissions) which made recommendations on the funding of these services, primarily special education and related services.

Major changes also occurred in the State's foster care system in the late 1970's and early 1980's. The creation of the Foster Care Review Board in 1978 required closer review of the children in care as well as the development of appropriate plans for permanent placement of these children. Implementing the requirements of federal and state law, the Department of Human Resources launched a demonstration program to reunify foster children with their families. Through this effort and related activities to prevent children from entering foster care unnecessarily, the State's foster care caseload dropped from over 9,000 children in 1981 to approximately 5,000 children in 1985.

During the same period of time, children being served by the Mental Retardation and Developmental Disabilities Administration, Juvenile Services Administration, Mental Hygiene Administration, as well as the Social Services Administration were impacted by the prevailing state philosophy on deinstitutionalization which called for movement of children out of large state institutions and into community settings. In all of these service systems, emphasis was placed on serving children in the "least restrictive environment" i.e., in their own homes and communities, or in settings which most approximated a home and community environment.

All of these initiatives to serve special needs children have required the infusion of state and federal resources to provide those in-home and community services which make it possible for children with special needs to remain in their homes. The expansion of these services has been difficult in the face of federal budget cuts which significantly reduced federal funding for these services. Cuts in Title XX social service programs, food stamps, AFDC, the Special Supplemental Food Program for Women, Infants, and Children, Medicaid, and preventive health services had a serious impact on services available to special needs children. While the Governor and the Maryland Legislature attempted to mitigate these reductions, the shortage of resources for critical services remains a serious problem. As this Plan makes clear, the provision of adequate services to Maryland's special needs children will require continued federal and state investment.

GOALS OF THE INTERAGENCY PLAN

1. To establish a continuum of care for children with special needs.
2. To ensure the interagency coordination of social, mental health, health, education and other human services to children with special needs.
3. To expedite the development of primary prevention programs aimed at strengthening families and maximizing the physical, social, and emotional well being of their children.
4. To remove barriers which impede the delivery of services to children with special needs.
5. To ensure that funding resources are directed at providing the most appropriate care for children by:
   a. maximizing federal and private sector resources to make the best use of state resources; and
   b. maximizing effective linkages to achieve interagency financing where appropriate.
6. To facilitate the movement of children among the various available services with emphasis on common intake, tracking and case management procedures.
7. To establish priorities for the future development of services across multiple state agencies and with the private sector.
8. To promote better communications with the private sector, existing child advocate groups, and families with special needs children to increase advocacy for children's services.

CHILDREN WITH SPECIAL NEEDS

Who are Maryland's children with special needs? What are their needs? The following general definitions clarify who is to be covered under this Interagency Plan. The definitions used here are not technical, program eligibility definitions; the specific legal definitions and program eligibility criteria are defined in federal laws, state laws, and program regulations and can be obtained from each agency or its local counterpart. Legal definitions included in the Annotated Code are cited below after each description.

A special needs child is any child who has one or more of the problems described below and who needs the programs, services or funding of one or more State agencies or their local counterparts.

Abandoned An abandoned child is one who is out of the care of his or her parents and the parents are unknown or cannot be located.

Abused An abused child is one who has sustained a physical injury, as a result of cruel or inhumane treatment or as a result of a malicious act by any parent or other person who has permanent or temporary care or custody or responsibility for supervison of a child. Included in this definition is sexual abuse of a child, whether physical injuries are sustained or not. (For legal definition see §5-901, Family Law Art., Ann. Code of Md.)

Chemical Abusers A child who is a chemical abuser is one who lacks control in the use of alcohol or drugs. For adolescents, some of the early signs of

abuse and addiction are: changes in friends; loss of interest in school or activities; inability to maintain structure; carelessness in appearance; and drinking or drug use at inappropriate times. (For legal definition see §103, Art. 2C, Ann. Code of Md.)

Child in Need of Assistance (CINA) A Child in Need of Assistance (CINA), is a child who requires the assistance of the court because he or she is mentally handicapped, or is not receiving ordinary and proper care and attention, and his or her parents, guardian or custodian are unable or unwilling to give proper care and attention to the child and his or her problems. (For legal definition see §3-801, Court and Judicial Proceedings Art., Ann. Code of Md.)

Child in Need of Supervison (CINS) A CINS child is one who is found by the court to be in need of guidance, treatment or rehabilitation and who has committed non-delinquent acts or offenses applicable only to children within this category. These offenses generally relate to habitual truancy by a youth required by law to attend school; habitual disobedience, ungovernability and behavior beyond the control of the persons having custody; a juvenile who acts in such a way as to endanger or injure himself or others; and/or a juvenile who commits an offense applicable only to children, such as running away from home. (For legal definition see §3-801, Court and Judicial Proceedings Art., Ann. Code of Md.)

Delinquent A delinquent child is one who is found by the court to have committed a delinquent act and requires guidance, treatment, or rehabilitation. A delinquent act is generally an act which would be a crime if committed by an adult. Both guilt for the act and the need for care must exist for the court to adjudicate the child as a delinquent. (For legal definition, see §3-801, Judicial Proceedings Art., Ann. Code of Md.)

Developmentally Disabled A developmentally disabled child is one who has a physical and/or mental condition which is of a severe nature, originates at birth or prior to age 22, does not include a sole diagnosis of mental illness, and is expected to continue indefinitely. A child who has a developmental disability requires a combination of coordinated services which are individually planned and based on the needs specific to the individual.

Educationally Handicapped An educationally handicapped child is one who has temporary or long-term special educational needs arising from cognitive, emotional or physical factors, or any combination of these. The child's ability to meet general educational objectives must be impaired to a degree whereby the services available in the general education program are inadequate in preparing the child to achieve his or her educational potential.

An educationally handicapped child may have one or more of the following conditions: deafness, deaf-blindness, hearing impairment, mental retardation, multi-handicaps, orthopedic impairment, other health impairment, specific learning disability, speech impairment, emotional disturbance, or visual impairment. Definitions of educationally handicapping conditions are found in Appendix A. (For legal definition see §8-401, Education Art., Ann. Code of Md.)

Mentally Disordered/Emotionally Disturbed/Behaviorally Disordered A mentally, emotionally or behaviorally disturbed child or

adolescent is one who exhibits psychological or behavioral patterns which are associated with distress and/or disability. For the child who is considered to be primarily emotionally disturbed, the referring problem for treatment or diagnosis is often associated with feelings of distress such as depression, high anxiety, or excessive worries. These distresses may be associated with impaired functioning such as sleep disorders, academic underachievement, etc. For the child who is considered primarily behaviorally disordered, the referring problem is often associated with behaviors which may be problematic for both the child and his environment. Examples of such kinds of behavioral problems include difficulty with proper conduct, hyperactivity, or attention deficits.

Usually, emotionally disturbed and behaviorally disordered conditions are not mutually exclusive. A child may be referred for service, for example, because of misbehavior at school. This misbehavior may be a symptom, however, of emotional distress which may in turn be related to problems in the family, e.g., divorce, death of parent or sibling. In the most severe forms of mental disorders, such as schizophrenia, there is often distress and severe impairment in many areas of functioning such as school performance, interpersonal relationships, and self-help skills. (For legal definition see Title 10, Health-General Art., Ann. Code of Md.)

Mentally Retarded A child with mental retardation is one whose disability is the result of a combination of subaverage intellectual function as well as deficits in the ability to function as non-disabled children do in the routines of daily living such as learning, socializing, caring for one's self, and making appropriate decisions. (For legal definition see §7-101(h), Health-General Art., Ann. Code of Md.)

Neglected A neglected child is one who has suffered or is suffering significant physical or mental harm or injury from the absence of the child's parents, guardian, or custodian; or the failure of the child's parents, guardian, or custodian to give proper care and attention to the child and the child's problems in circumstances that indicate that the child's health or welfare is harmed or threatened. (For legal definition see §5-701, Family Law Art., Ann. Code of Md.)

Physically Disabled A child with a physical disability is one who has a manifested condition relating to the human body that interferes with his or her ability to function in a normal setting without the need for supervision or assistance other than that which is age appropriate.

Children with Multiple Problems A child with multiple problems is one who has a combination of problems and does not fit into any one of the categories listed above. These include: the violent emotionally disturbed child or adolescent; the dual-diagnosed or multiple-diagnosed child or adolescent (e.g., a child who is mentally retarded and has cerebral palsy and mental health problems); the child whose behavior is socially unacceptable and whose home situation is less than satisfactory; the non-educationally handicapped child or adolescent who has a 70-90 I.Q. and is culturally deprived; the non-educationally handicapped child or adolescent who is socially maladjusted; and the handicapped child whose parents are unable to provide residential care and for whom long term care is needed.

A CONTINUUM OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS

The most useful way to conceptualize the range of services needed by Maryland's children with special needs is as a ***continuum of services*** which can respond to different types of children's problems and different intensities of need. The continuum must encompass broad-based prevention programs which can promote the development of all children, as well as the very specialized services that are critical to a small number of handicapped children.

As a framework for analyzing and developing Maryland's system of children's services, the Interagency Planning Committee for Children defined a continuum of services with five major categories of service:

I. **Primary Prevention Activities**
II. **Early Intervention Services**
III. **Evaluation, Assessment, and Diagnosis Services**
IV. **In-Home and Community Services**
V. **Substitute Care Services**

Within each of these categories, specific service components are identified as the essential "building blocks" of the service continuum. A complete listing of the continuum of services is shown in Figure 1.

In developing the continuum the following general principles were considered:

- Services should be accessible to all children with special needs and should be provided in a timely and flexible manner, allowing for transition among services and service agencies.
- Services should be based on an individualized plan for each child which is appropriate to the child's needs, in accordance with the child's age, developmental level, strengths, and weaknesses.
- Services should be delivered in the least restrictive setting appropriate to the child's needs.
- Services should involve the family to the greatest extent possible.
- Services should be focused on establishing a stable life situation for each child.

The continuum represents the ideal range of services that would be available to special needs children. In Maryland, as in other states, the continuum is a reality only in part. Some services are more fully developed than others, and certain target populations of children are better served than others. Before setting forth recommendations for each part of the continuum, it is useful to discuss some conclusions about the continuum as a whole.

The State's continuum is in fact several different, although related, continuums, because each State agency tends to build its own version of the continuum for the children it serves. A major goal of the Interagency Plan has been to promote shared, cross-agency development of the continuum whenever feasible, so that agencies will jointly develop and fund resources rather than build parallel service systems.

The "front-end" of the continuum, i.e., primary prevention services, is more difficult to approach than the more intensive forms of care. Investment in these services, except for the variety of health care services, has

Figure 1

A CONTINUUM OF SERVICES

FOR MARYLAND'S SPECIAL NEEDS CHILDREN

I. PRIMARY PREVENTION ACTIVITIES

- A. Community Education
- B. Primary Health Care

II. EARLY INTERVENTION SERVICES

- A. Information and Referral
- B. Programs to Identify and Prevent Developmental Problems in At-risk Children
- C. Parent Education or other Parent Support Programs

III. EVALUATION, ASSESSMENT, AND DIAGNOSIS SERVICES

IV. IN-HOME AND COMMUNITY SERVICES

- A. Family and Individual Counseling
- B. Outpatient Psychiatric Therapy
- C. Respite Care
- D. Day Education/Treatment Programs
- E. Recreation/Social Programs
- F. Personal Care
- G. Day Care (including Before and After School)
- H. Specialized Equipment and Housing Adaptations
- I. Transportation (to and from services)
- J. Vocational Education and Transitioning Programs
- K. Tutoring
- L. Specialized Medical Services
- M. Self-Help Services
- N. Volunteer Services
- O. Adoption Services

V. SUBSTITUTE CARE SERVICES

- A. Emergency and Shelter Care
- B. Family Foster Care
  - 1. Specialized Foster Care
  - 2. Regular Foster Care
- C. Residential Services
  - 1. Alternative Living Units (ALU)
  - 2. Group Homes (including therapeutic group homes)
  - 3. Small Residential Centers
  - 4. Non-Public Special Education Facilities
  - 5. Residential Treatment Centers
  - 6. Psychiatric Hospitals
  - 7. Detention and Commitment Institutions

been restrained. The slower growth of prevention services is due in part to limitations of resources and in part to a continuing uncertainty about which "preventive" service approaches are successful in ameliorating future problems.

All agencies are readjusting funding priorities to give greater emphasis to in-home and community services. As a result, this area of service requires the most intensive coordination among agencies over the next several years. As State agencies develop community services to keep children with their families, the danger is that specialized family service programs will proliferate, any one of which will respond to only one type of family problem. While specialized services are necessary and inevitable, the goal of this Plan is to ensure that these are developed in the context of a broader plan for family services and supports.

Although substitute care is the area of the continuum with the most complete resource development, substantial changes are occurring and are necessary in that portion of the continuum as well. Changes in the needs of children requiring foster care and other forms of residential care are requiring that these programs be reshaped and expanded, adding more intensive treatment services and new forms of care. Further, the emphasis which each agency places on preventing unnecessary institutional care should not be construed as giving reduced importance to high quality, appropriate care in residential settings. Many children still require this care.

Any overview of the continuum must recognize real constraints on the availability of services. Although many resources do exist on a statewide basis, availability of services in the continuum still varies by jurisdiction. Certain areas of the State, particularly rural areas and western Maryland and the Eastern Shore, still have relatively few of the specialized care resources which State agencies are developing. Even within the metropolitan counties, access to services can vary by jurisdiction.

Finally, many service resources are underfunded in relation to need. Just because a service in the continuum exists in Maryland does not mean that it meets full need. Even some of the most readily available services are not able to respond to all children and families who might benefit from the service.

In summary, the continuum is not a static array of services, but a variety of service programs among which the emphasis of services must change constantly, in which the linkages among services must be continuously strengthened, and from which children and families draw differing degrees of support at different times.

The goal of this Interagency Plan is to identify more clearly the cross-agency priorities for developing this continuum and thus to impart more direction to the way in which the continuum evolves.

In the narrative which follows, each major section of the continuum is discussed. For each, a brief description and analysis of current services is provided, followed by the agencies' priorities for future development.

I. PRIMARY PREVENTION ACTIVITIES

Primary prevention activities are services or programs designed to promote a child's physical, social, and emotional growth, and thereby avert problems before they arise. In a general sense, the concept of primary prevention is widely accepted. Basic services such as primary health care for young children can and do prevent later physical problems. In other contexts, however, the concept of "prevention" remains elusive. For example, evidence is mixed about which services can "prevent" delinquency. No one knows fully how to "prevent" child abuse, although a variety of activities can help to protect children from it.

For the purpose of this Plan, primary prevention activities are those services provided by State agencies because they are believed to avoid or alleviate the subsequent problems which State agency services must then address.

Analysis of Current Programs

Primary prevention activities administered or funded by DHR, DHMH, or MSDE are shown in Figure 2. These fall into two categories. First, programs such as public education and/or primary health programs are widely available to a broad spectrum of families and children. Primary health care services best represent this type of prevention service. For example, the Preventive Medicine Administration and local health departments coordinate a wide range of primary care programs, including maternal and child health clinics, Early and Periodic Screening Diagnosis and Treatment (EPSDT) programs, and Special Supplemental Food for Women, Infants and Children (WIC).

Day Care for Children (more fully discussed under In-Home and Community Services) is also considered an important prevention service as it often provides the opportunity for routine health screening, parent education and informal observation of a child's health and development. Although State agencies do not provide day care directly, SSA administers a purchase-of-day care program which subsidizes care for low income families. DHR, through SSA, DHMH, through PMA, and MSDE also license and certify group child care settings and family day care homes.

All of these increase the health knowledge of families and children and thus help to prevent health and developmental problems. Similarly, school health programs aimed at increasing children's knowledge of health care as well as screening, detecting and treating health problems, are preventive in the truest sense of the word.

A second type of primary prevention service is targeted at reducing the likelihood of a specific problem. Current state-funded programs of this type include the child abuse prevention grants (HELP mini-grants) funded by the Social Services Administration, and the alcohol and drug education programs supported in the public schools by the Drug Abuse Administration and the Alcoholism Control Administration.

Priorities for Future Development

To further develop State support of primary prevention activities, the following objectives should be pursued:[1]

Objective: Strengthen the base of primary health care programs for children

TASK #1: DHMH, through the Medical Assistance Administration and in conjunction with the Preventive Medicine Administration, should continue to expand the EPSDT program to ensure coverage of all income eligible children in the State.

[1]There are a number of primary prevention programs related to adolescent pregnancy discussed in the Final Report of the Governor's Task Force on Teen Pregnancy. These are not repeated here.

Figure 2

I. PRIMARY PREVENTION ACTIVITIES

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
A. Community Education				
Youth Services Bureaus	DHMH/JSA	5000	20 bureaus in 8 jurisdictions	$500,000
Alcohol and Drug Abuse Prevention in Schools	DHMH/DAA/ACA	30,000	statewide	$500,000
Child Abuse Prevention Grants (9 grants)	DHR/SSA	— —	7 jurisdictions	$155,000[2]
B. Primary Health Care				
Child Health Services	local health departments	61,000	statewide	(Case Formula)[3]
Immunization Program	DHMH/PMA	86,000	statewide	$210,000[4]
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	DHMH/PMA	56,946	statewide	$1,900,000[5]
Maternal Health Prenatal Clinics	DHMH/PMA	8,856	statewide (except St. Mary's County)	$270,982[6]
Women, Infants, Children Supplemental Food Program (WIC)	DHMH	48,500	statewide	$20,000,000

[1] *Total funds for FY 86 unless otherwise noted*
[2] *FY 86 federal funds*
[3] *The formula used by DHMH to fund local health services*
[4] *FY 84 federal funds*
[5] *FY 84 total funds*
[6] *FY 85 Maternal and Child Health Block Grant and state-funded Project 201*

Currently, the program is estimated to serve 35 percent of the population which could benefit from its services, yet this program remains one of the basic safety net programs which can help ensure the healthy development of children. It is recommended that Medical Assistance expand outreach to poor families, increase efforts to make the public aware of the program and work with public schools to link eligible children to the diagnostic services available through the program.

Objective: Develop a comprehensive statewide strategy for the prevention of children's disabilities

TASK #2: DHMH, through MRDDA, will prepare a three-year statewide plan focusing on prevention activities related to children's disabilities.

The Mental Retardation and Developmental Disabilities Administration has been awarded a $40,000 grant from the Maryland Developmental Disabilities Planning Council to develop a three-year statewide plan regarding different levels of prevention of developmental disabilities. To develop the plan, MRDDA will use an interagency task force to evaluate unmet needs and then develop a plan of action focusing on health service delivery, research and training, education, coordination, and outreach as well as other similar needs.

Objective: Expand program models which incorporate prevention-related activities along with direct treatment services.

TASK #3 DHMH, through JSA, should develop a plan for the expansion of Youth Services Bureaus which provide community-based delinquency prevention services and daily supervised activities for teens.

The Youth Service Bureaus are one of the few programs specifically targeted at delinquency prevention for adolescents. The goal is to broaden the coverage from 30,000 to 40,000 adolescents and to develop programs in geographic areas which are currently not covered.

II. EARLY INTERVENTION SERVICES

Early intervention services are those services which provide early identification, assessment, and prompt service in order to head-off, shorten the duration of, or resolve a problem before it worsens. For this Plan, early intervention means involvement with a child or adolescent soon after a problem has been identified in order to prevent its escalation.

Within this area of the continuum, three major services are identified: (1) information and referral services; (2) programs to identify and prevent developmental problems in at-risk children; and (3) parent education or other parent support programs.

Analysis of Current Programs

The early intervention services administered or supported by State agencies are shown in Figure 3. As can be seen, these services have been more extensively developed than primary prevention services. This reflects deliberate targeting of these services to high risk groups of children or to specific problems where intervention is known to have a significant impact. Numerous children receive these services each year, an indication that many children's problems, particularly health problems, are likely to be identified and assessed at an early age.

The first service shown on Figure 3 is Information and Referral. In this Plan, Information and Referral (I&R) means an organized I&R service which has as its main purpose the provision of information about services, then help to connect (refer) people with those services.[1]

In Maryland, there are two statewide information and referral services. The most comprehensive is the Information and Referral service offered by the Health and Welfare Council ("First Call for Help") which is funded by DHR, DHMH, the Department of Employment and Training, Baltimore City, and the United Way. This service operates statewide on a toll-free telephone line; it is not focused specifically on children's services, but includes them as part of a generalized I&R service. A second I&R service which is targeted at special needs children is the Information and Referral Service for the Handicapped, funded by MSDE. This program provides specific information on services for the handicapped including information on special education.

It is in the second category of early intervention services. Programs to Identify and Prevent Developmental Problems in At-Risk Children, that the major coverage of children occurs. A variety of federally and state-mandated programs in this area result in assessment and, if necessary, intervention services for many thousands of children per year. These include services which are available to all children, such as school health services which screen all public and private school children for scoliosis, hearing and vision, and immunization status as well as

[1]To a greater or lesser degree, this service is provided by all State agencies and through many programs. That is, any service program is likely to refer families to other programs when another program is believed to be more appropriate.

Figure 3

II. EARLY INTERVENTION SERVICES

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
A. Information and Referral				
Information and Referral	*(see below)*[2]	30,500	statewide	$346,000[2]
Information and Referral for the Handicapped	MSDE	13,500	statewide	$50,000
Crippled Children's Program	DHMH/MRDDA	(see Figure 5, Specialized Medical Services)	statewide	(see Figure 5, Specialized Medical Services)
JSA Intake[3]	DHMH/JSA	36,000	statewide	$3,500,000
B. Programs to Identify and Prevent Developmental Problems				
Crippled Children's Program	DHMH/MRDDA	(see Figure 5, Specialized Medical Services)	statewide	(see Figure 5, Specialized Medical Services)
Hereditary Disorders Program	DHMH/PMA	72,000	statewide	$639,000
School Health Services	DHMH/PMA	674,000	statewide	(Case Formula)[4]
Special Program for Infants and Young Children	DHMH/MHA	150	Central Maryland	$425,800
Lead Poisoning Prevention	DHMH/PMA	45,000	statewide	(Case Formula)[4]
EPSDT	DHMH/PMA	(see Figure 2, Primary Prevention)	statewide	(see Figure 2, Primary Prevention)
Maryland Regional Neonatal Program	DHMH/PMA	650 transports	Metro Baltimore (statewide access)	$365,000
Maryland High-Risk Infant Follow-up Program	DHMH/PMA	2000	Baltimore City, Baltimore County, Washington County	$248,600
C. Parent Education or Other Parent Support Programs				
Family Support Centers	DHR/SSA	500 families	Baltimore City, Anne Arundel County, Prince George's County	$397,000[5]
Family Support Services	DHMH/MRDDA	150	Baltimore City, Baltimore County, Frederick County, Calvert County, Montgomery County, Eastern Shore	$220,000
Parent Education Training Program	MSDE	500 families	statewide	$55,000[6]

[1]Total funds for FY 86 unless otherwise noted
[2]This is "First Call for Help," a 24-hour information and referral hotline provided by the Health and Welfare Council. It is jointly funded by DHR, DET, DHMH, Baltimore City and the United Way.
[3]Services include screening, information and referral and short-term intervention
[4]The formula used by DHMH to fund local health services
[5]FY 86 general funds of $297,000 supplemented by $50,000 from the Goldseker Foundation and $50,000 from the Aaron and Lillie Straus Foundation
[6]Local, state and federal funds

screening of newborns for hereditary and metabolic disorders. These services are available on a statewide basis.

Other screening programs are targeted to specific at-risk populations. These include child health services provided in child health clinics of local health departments, which focus on Medicaid-eligible and low income children. The Lead Poisoning Program also screens over 45,000 children annually and

provides counseling about the effects of increased lead absorption. The Crippled Children's program administered by MRDDA also provides screening and early intervention to approximately 14,000 children through local health departments, private providers, and community health agencies.

In addition to the above programs which are operated on a statewide basis, State agencies are testing differing approaches to early intervention services on a pilot basis. One of these is the Mental Hygiene Administration's support for the Regional Center for Infants and Children, a private non-profit program which focuses on early identification of mental health problems in infants and young children. This program provides a broad array of diagnostic, evaluation, and treatment services to infants, young children and their families who are at early risk of dysfunction due to mental health problems, addictions or related family problems.

The Mental Hygiene Administration also funds training for mental health clinic staff in providing clinical interventions for infants and parents to avert the development of serious emotional difficulties. This training has led to the establishment of infant psychotherapy programs within community mental health clinics. The infant psychotherapy programs promote more adequate parenting skills which enhance more positive development for both the infants and their families.

A third type of early intervention program being tested by State agencies focuses not just on children's problems, but on providing support to the family unit as a whole. Underlying this approach is a belief that strong and well-functioning families are the key to heading off or coping with children's emotional, physical, or behavioral problems. Two programs, similarly titled but funded by different agencies and with different purposes, reflect this approach. SSA's demonstration Family Support Center program, new in FY 1986, provides a range of supports to young parents, particularly teenagers in order to help these parents be more self-sufficient, to avoid further unwanted pregnancies, and to better care for their children. The program is designed to intervene early to prevent family dissolution, poor child-rearing practices, and ultimately, child abuse. MRDDA's Family Support Services provides a range of services to enable children with developmental disabilities to remain with their families. Among the services offered are counseling, parent education, support and special equipment.

In summary, these early intervention services are an extremely important part of the continuum. They are often the "first attack" on the problems of special needs children. In addition, identification and treatment of problems early in life may prevent further progression of the problems and more expensive treatment in adolescence and adulthood.

Priorities for Future Development

In the development of this Plan, two major problems were identified in the area of early intervention services. First, there are no broad-based programs which focus on the early identification and treatment of children's mental health problems. Second, there is concern that the existing information and referral systems are not well known and utilized. In addition, the most promising of the current programs which intervene early with high-risk families and children should be carefully examined and expanded as appropriate. The strategy in this area will focus on remedies for these problems.

Objective: Expand mental health early intervention programs

TASK #1: DHMH, through the Mental Hygiene Administration, should expand mental health early intervention programs for children from birth to age five at risk of psychosocial and developmental dysfunction.

This would include infants and young children whose parents have histories of mental illness, mental retardation, substance abuse or primary care givers who are incapacitated or experiencing considerable stress. By expanding staffing and increasing consultation activities with local health clinics, day care centers, nursery programs and elementary schools, a greater percentage of the at-risk population could be evaluated and treated earlier in their lifetimes.

Objective: Enhance existing information and referral services available to special needs children

TASK #2: The Governor's Office for Children and Youth, in conjunction with the Maryland State Department of Education, the Department of Human Resources and the Department of Health and Mental Hygiene, should develop a plan to ensure that existing information and referral services reach the families of special needs children.

The plan should consider outreach activities, publicity campaigns, publications directories, and other activities to better reach this population. This plan should be completed by June 30, 1986 and implementation completed by June 30, 1987.

Objective: Evaluate and, as appropriate, expand services which strengthen parenting capacities and general family functioning.

TASK #3: DHR, through SSA, will evaluate its pilot program of family support centers which is in its first year of pilot testing in FY 1986. If results of the ongoing evaluation are positive, SSA will plan to increase the size of this program in FY 1987 and FY 1988.

III. EVALUATION, ASSESSMENT AND DIAGNOSIS

Evaluation means a full range of assessments completed by qualified examiners to help diagnose problems and concerns relating to an educationally handicapping condition, medical or health disability, chemical dependence problem, developmental disability, or psychological/mental health problem. The results of the assessment(s), which must be administered by a properly trained, qualified examiner, should be used to assist in focusing on the individual child's total needs. Evaluation services, as described above, are available through local agencies and departments that serve each jurisdiction in the State of Maryland.

Evaluation, assessment, and diagnosis are critical to the development of any child's service plan. Each child must be carefully and thoroughly evaluated to determine the best and most appropriate service plan.

Analysis of Current Programs

Current evaluation activities are a combination of public and private efforts (See Figure 4). Some agencies such as the Special Education Divisions of local public schools and the Juvenile Services Administration have very structured and identifiable evaluation programs. For example, prior to entry into any public school special education program, each child is thoroughly evaluated by the local

Figure 4

III. EVALUATION, ASSESSMENT, AND DIAGNOSIS SERVICES

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
Clinical Services	DHMH/JSA	8000	statewide	$322,400
Local Assessment (ARD Process)	MSDA/LEA	90,000	statewide	— —
Assessment and Evaluation of Foster Children	DHR/SSA	2000	statewide	— —
Mental Health Evaluation Services	DHMH/MHA	(see Figure 5, Outpatient Therapy)	statewide	(see Figure 5, Outpatient Therapy)

[1]*Total funds for FY 86 unless otherwise noted*

Admission Review and Dismissal (ARD) team and an Individual Education Plan (IEP) is developed.

Similarly, the Juvenile Services Administration contracts with private agencies and individual psychiatrists and psychologists to provide psychological evaluations for approximately 8000 delinquent and CINS youth under 18 years of age. There are staff or contractual clinicians at some JSA institutions who evaluate youth after they are detained or committed to a particular institution.

Local departments of social services consider diagnosis and evaluation an integral part of every service. If a child who is the subject of a child abuse or neglect report requires a physical or mental health assessment, it is arranged through an appropriate provider. In the foster care program, all children receive regular physical examinations. Any foster child with special emotional, mental, or behavioral problems receives a psychological or psychiatric examination as well.

All children and adolescents seen in Mental Hygiene Administration (MHA) mental health clinics as well as residential treatment and inpatient programs receive thorough evaluations, assessments and diagnoses which culminate in individual treatment plans. Participation in the evaluation and treatment planning process is usually multidisciplinary.

The fact that each agency secures evaluations in a different way can in itself be a problem, when more than one agency must serve a child. An attempt to structure some uniform guidelines for at least reporting an evaluation is being developed by the State Coordinating Council (SCC) on behalf of the children referred to it for residential care. The SCC is also developing a common evaluation package which will use existing information to the extent possible (such as the Individual Education Plan (IEP)) in evaluating a child for residential placement.

Priorities for Future Development

The Interagency Planning Committee for Children identified several problems in this area which warrant priority action. First, while each agency has a diagnosis and assessment mechanism, there is insufficient coordination between agencies where diagnosis and evaluation of the same child is concerned. A child may often receive multiple evaluations which essentially confirm the previous diagnosis.

A second problem is that, in spite of the number of agencies focusing on special needs children, there are some children with multiple problems for whom comprehensive evaluations are difficult to obtain because of funding problems. In particular, children who enter the juvenile justice system, but for whom Medicaid reimbursement is not available to cover the costs of assessment, may lack full assessments. Thus, providing adequate assessments for these "uncovered" children is a priority. (See "Interagency Issues" - Uncovered Children)

The strategy in this area should focus on two objectives.

Objective: Reduce duplication in evaluation of the same children by establishing procedures by which agencies share information.

TASK #1: Each state agency serving children (MSDE, SSA, JSA, PMA, MHA, MRDDA, ACA/DAA) and their local agencies should have within the agency standardized intake forms which are used consistently throughout the state.

The formats for each agency should be shared with all other agencies so there is a common understanding of the intake process in each agency. While some agencies already have such forms, the agencies which do not should develop a standardized format by October 1, 1986.

TASK #2: MSDE (through local education agencies), SSA (through local departments of social services), JSA, MRDDA, ACA/DAA, and MHA should, to the extent permitted by law, make their written evaluations of specific children available and accessible to other State and local agencies involved in care planning for the child.

By October 1, 1986, agencies should develop written procedures for sharing their evaluations, if such procedures do not currently exist. This is to reduce redundant evaluations, yet give each agency the benefit of the evaluations already completed.

TASK #3: DHMH, through JSA, should develop comprehensive localized assessment capabilities for youth who are referred for substitute care through JSA.

To the extent practical and feasible, JSA should coordinate these assessments with other agencies (SSA, MHA, ACA/DAA) who may have already done evaluations on the same child. The assessment teams are to be operational by the end of FY 1986.

IV. IN-HOME AND COMMUNITY SERVICES

In-Home and Community Services are those services provided to support a family living situation for a child, thereby preventing out-of-home care unless such care is clearly in the best interest of the child. In-home and community services are also provided to assist a child and his or her family when the child has returned home from a substitute care program.

An effective continuum of in-home and community services requires a number of discrete services, as shown in Figure 5. In general, the services in this area can be divided into five major sets of activities:

- Those services that directly support the physical maintenance of a child in his or her home including specialized equipment, special medical services, and personal care.
- Those services dedicated to education and socialization, including day education/treatment, vocational education, tutoring and recreation.

Figure 5

IV. IN-HOME AND COMMUNITY SERVICES

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
A. Family and Individual Counseling				
Single Parent Services	DHR/SSA	1600	statewide	$1,012,000
Intensive Family Services	DHR/SSA	600 families	13 jurisdictions	$1,200,000
Continuing Protective Services	DHR/SSA	4100 families	statewide	$12,938,000[2]
Services to Families with Children	DHR/SSA	3000 (amc)	statewide	$8,300,000
Youth Services Bureaus	DHMH/JSA	10,000	20 bureaus in 8 jurisdictions	$1,000,000
Diversion Programs	DHMH/JSA	1941	Baltimore City, Prince George's County	$900,000
Probation and Aftercare	DHMH/JSA	7022	statewide	$8,000,000
In-Home Alternatives to Detention and Commitment	DHMH/JSA	1500	5 jurisdictions	$1,200,000
Community Arbitration	DHMH/JSA	4200	Baltimore City, Prince George's County, Anne Arundel County, Baltimore County	$580,000
Family Support Services	DHMH/MRDDA	(see Figure 3, Parent Education)	14 jurisdictions	(see Figure 3, Parent Education)
Adolescent Pregnancy and Prevention	DHMH/PMA	1333	15 jurisdictions	$213,000
B. Outpatient Psychiatric Therapy				
Outpatient Therapy for Chemically Dependent Adolescents	DHMH/DAA/ACA	2000	statewide	$750,000
MHA Clinic Programs	DHMH/MHA	4715 (admissions)	statewide	$3,200,000[3]
Purchase of Service	DHMH/JSA	2336	statewide	$1,100,000
C. Respite Care				
Respite Care	DHR/SSA	615	statewide	$465,000
D. Day Education/Treatment				
RICA 1, 2, 3	DHMH/MHA	230 slots	12 jurisdictions	$5,400,000[4]
Frederick County Day Education Program	DHMH/MHA	21 slots	Frederick County	$114,000
Purchase of Service	DHMH/JSA	400	statewide	$429,000
Good Shepherd Day Program	DHMH/JSA	42	Baltimore City, Baltimore County	$78,500
Murphy Youth Centers	DHMH/JSA	100 (ade)	Baltimore City	$700,000
Special Education[5]	MSDE/LEA'S	88,022	statewide	$255,000,000[6]
Special Education[7]	MSDE/Non-Public and State-Operated Programs	1273	statewide	$9,400,000[8]
E. Recreation/Social Programs				
Summer Day Program	DHMH/MRDDA	1953	statewide	$247,700
Youth Services Bureaus	DHMH/JSA	15,000	20 bureaus in 8 jurisdictions	$400,000
F. Personal Care				
In-Home Aides/Parent Aides	DHR/SSA	943 (amc)	statewide	$2,500,000

IN-HOME AND COMMUNITY SERVICES (continued)

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
G. Day Care				
Day Care	DHR/SSA	7445 slots[9]	statewide	$16,350,000[9]
Family Support Services	DHMH/MRDDA	(see Figure 3, Parent Education)	14 jurisdictions	(see Figure 3, Parent Education)
H. Specialized Equipment and Housing Adaptations				
Crippled Children's Program	DHMH/MRDDA	(see Specialized Medical Serices)	statewide	(see Specialized Medical Services)
Family Support Services	DHMH/MRDDA	(see Figure 3, Parent Education)	14 jurisdictions	(see Figure 3 Parent Education)
I. Transportation	MSDE/LEA	*(see below)*[10]	statewide	(included in regular transportation budget)
J. Vocational Education				
Murphy Youth Centers	DHMH/JSA	(see Day Education)	Baltimore City	(see Day Education)
Purchase of Service	DHMH/JSA	100	statewide	$54,000
Public Schools	MSDE/LEA's	1110	statewide	$2,476,000
Academic/Vocational Programs	DHMH/JSA	500	statewide	$428,866
K. Tutoring[11]				
L. Specialized Medical Services				
Crippled Children's Program	DHMH/MRDDA	14,000	statewide	$5,000,000
M. Self Help	DHMH/ACA/DAA	20,000	statewide	*(see below)*[12]
N. Volunteers				
Foster Grandparents	DHMH/JSA	500	5 jurisdictions	$181,000
Volunteers	DHMH/JSA	1880	statewide	$103,000
O. Adoption				
Subsidized Adoption	DHR/SSA	1395 (amc)	statewide	$3,900,000

[1] *Total funds for FY 86 unless otherwise noted*
[2] *Total Protective Services funding; includes investigations as well as continuing services*
[3] *FY 86 funding*
[4] *State funds only. Local education agencies also contribute*
[5] *This reflects Levels I-V special education services provided in local education agencies*
[6] *FY 84 funding*
[7] *This reflects Level V Special Education services provided in approved non-public day programs and state-operated day programs*
[8] *FY 84 funding*
[9] *Day Care is provided to handicapped children and also as part of a protective services treatment plan. However, the number of special needs children served and the funding for their care is not broken out separately; the data here is for the total purchase of day care program.*
[10] *Available if needed as part of an Individual Education Plan (IEP)*
[11] *An important part of the continuum, but not currently offered by any agency*
[12] *This includes Alcoholics Anonymous, Narcotics Anonymous, Alateen and Alanon (for family members of persons with alcohol abuse problems). No state funding is provided.*

- Those services directed at a child's or family's emotional well-being or special mental health needs such as counseling, out-patient therapy, volunteers, and self-help groups.
- Those services which, by providing short-term, alternative care arrangements, are critical to enabling a parent to assume overall care responsibilities for a child. Such services may include those which care for a child for part of a day (such as family day care or day care centers) or for longer periods of time, such as respite care programs.
- Adoption services, which are designed to provide a permanent home to a child whose natural parents cannot or will not retain parental custody of the child.

Analysis of Current Programs

The first category of services, *those designed to help maintain a child physically in the home*, have experienced only moderate growth in recent years. As Figure 5 indicates, specialized medical equipment and housing adaptations, and other special medical services, are provided through MRDDA's Crippled Children's Services to physically handicapped and developmentally disabled children. Similarly, MRDDA's Family Support Service program provides these services to a small number of families.

A further approach to helping families maintain a child in the home is taken by DHR/SSA's Parent Aide program. Parent aides assist families with the routines of daily living: housekeeping, shopping, child care, and so forth. The service is made available through local departments of social services, primarily for families where abuse or neglect has occurred. By relieving parents in crisis of the stress associated with these activities, parent aides can help to stabilize a family situation and even prevent the removal of a child from the home.

The second category of care, *services supporting a child's educational needs*, are the most predominant on the continuum, at least in terms of number of children serviced. As described earlier in this plan, implementation of federal law (P.L. 94-142), and comparable state law, has been one of the driving forces in maintaining children with special needs in the community. In Maryland in FY 1984, approximately 88,000 handicapped children were served in Maryland's public school special education programs.

In-school special education programs are supplemented in Maryland by other day education programs for children outside of public schools. Approximately 2,000 children were served in State-operated programs and non-public programs requiring state tuition assistance. The availability of these programs on a day attendance basis is a critical part of a community service strategy; previously, many children had to live in residential settings in order to receive these services. Day education programs of this type include the 230 DHMH/MHA day treatment slots in RICA programs, supervised by DHMH/MHA for emotionally disturbed children, and the special education placements in non-public educational facilities funded jointly by local and state education funds. However, demand far exceeds the supply of these services. In addition to the RICA's, both SSA- and JSA-supervised children participate in day educational programs of private providers, such as the Good Shepherd Day Program.

Other types of specialized educational programs are provided to special needs children, both in and out of public schools. Vocational education services, for example, can be an important educational alternative for special needs children. In addition to the public programs in these areas, JSA also provides limited funding for vocational education for the children it serves.

The third category of care, *services supporting a child's or family's general functioning or special mental health needs*, are the second most predominant on

the continuum. These services include a wide range of counseling services, as well as less formal types of support such as self-help groups.

The approaches taken to "counseling" vary greatly by agency. In many instances, counseling does not exist by itself as a discrete service, but is part of a broader program of community services that agencies make available to families. Because this is an area in which agencies are reshaping services, this group of services warrants further description.

For example, counseling is an integral part of JSA's Youth Services Bureaus (YSB's), which are JSA's main vehicle for serving pre-delinquent youth in a community setting. YSB's counseling services are delivered in a way that is appropriate for reaching adolescents. They involve not just traditional, one-on-one therapy, but often are part of a group process or recreational and social activity. The Youth Services Bureau's focus is on assisting young people to cope successfully in their family, school, and community environments; counseling activities are interwoven with the variety of activities that promote this goal.

Similarly, the Social Services Administration, through local departments of social services, is seeking to build a range of family services that adapt to the type of need a family may have. Continuing Protective Services are provided to families where there has been a report of abuse or neglect, and where on-going monitoring of the child's situation and/or support for the family is required.

A similar service, but one that recognizes that some families need even more support in order to care for their children, is SSA's Intensive Family Services (IFS) program. This program, like Continuing Protective Services, also serves families in which child abuse or neglect has occurred. It too, aims to ensure the safety of the child and, by resolving the crises that have resulted in abuse or neglect, prevents the child's entry into foster care. In IFS, however, the intervention with the family is more intensive. A social worker and parent aide team, using a purchase-of-service budget of up to $600 per child, meet other needs the family may have, including securing necessary furniture, making rent deposits, or purchasing more specialized therapeutic assistance. IFS addresses the many factors that, if not dealt with, can cause a child to be removed from the home.

SSA's family services include two other programs. The Services to Families with Children (SFC) program provides counseling to families who are facing crises or experiencing general dysfunction. While not targeted to children with special needs, the program serves many families who have disturbed children.

The Single Parent Service (SPS) program assists unmarried pregnant teenagers and teenagers with young children by providing information and referral, counseling assistance in moving back into school or employment, and assistance in securing appropriate health care or other services for the child. Single Parent Service also works to prevent future out-of-wedlock pregnancies and to provide support to these young families in order to prevent the occurrence of future problems for the child, the mother and the family.

Another important component of counseling services for children and families are the mental health services provided by the State through community mental health centers and supervised and funded by DHMH/MHA. These services involve a wide range of treatment modalities including family, group and individual therapy, drug therapy, etc. The mode of service delivery focuses primarily on clinic-based assessment and treatment. In some locations these services are provided by specialized child and adolescent mental health teams. In other areas, special staff is not available. Other agencies serving children and families, such as JSA, SSA, and MRDDA, refer to those services when families they serve require mental health counseling beyond the scope of the counseling services each agency provides.

The fourth category of in-home and community services is *services which provide care for a child for all or part of a day*, thereby assisting a family in its role of caring for the child. The primary service for this purpose is child day care, which many families require for all or part of a day in order for the parents to work. While state agencies no longer provide day care directly, SSA administers the purchase-of-day care program which subsidizes care for low-income families. Children who require care because of potential or actual abuse or neglect, or to avoid institutionalization, receive first priority in this program. In addition, the program provides special rates for children with handicapping conditions.

Another service in this category is respite care, which can assist families caring for special needs children, particularly children with severe emotional, mental, or physical handicaps. Respite care provides families with some temporary relief from the intensive care demands which these children require. However, respite care services in Maryland are few. Currently, SSA provides respite care for approximately 615 families of developmentally disabled children. There is no respite care in the State for emotionally disturbed children and their families.

The fifth category of services is *adoption services*, which provide a permanent home for a child who otherwise would not have one. The State's adoption service, administered through local departments of social services under DHR/SSA's oversight, develops homes for children in foster care. Increasingly, these are children with special needs, defined for purposes of adoption as older children, minority children, and sibling groups, as well as children with handicapping conditions. Through the State- and federally-supported subsidized adoption program, placement of these children has grown to over 1,400 children in FY 1986, a rapid increase in the past four years.

Another service, transportation, may be included as part of a service program. However, with the exception of transportation provided by local education agencies as part of a plan for the education of handicapped children, it is not separately identified in the Plan.

Finally, one service identified as necessary on the continuum of in-home and community services, tutoring, is offered on such a limited basis that it is not shown as part of any program.

Priorities for Future Development

While a large number of community-based services have been defined and are offered to some degree, overall the State still lacks a complete continuum of care in these areas.

In general, the best developed support systems are focused on specific target groups (children with mental retardation, delinquents, abused and neglected children). However, even for these populations, additional service resources are necessary if agencies are to meet the needs of children. In addition, certain gaps in the service continuum need to be filled. There continues to be an inadequate continuum of mental health services for children and adolescents. Services to prevent teenage pregnancy are desperately lacking. Respite care services, which are often critical to a family to allow them to maintain their children in the community, are minimal.

In view of these and other service gaps, the agencies' priorities for service development are shown below.

Objective: Expand community-based alternative education programs available to special needs children.

TASK #1: MSDE, working with JSA, SSA, MRDDA, ACA/DAA, and MHA, will promote the development of appropriate alternative academic and vocational programs for youth who do not function well in regular education settings and who require a program of individualized instruction that meets their specialized needs.

In order to maintain the range of special needs children in the community, priority must be given by local education agencies to an expanded range of educational options. By more flexibly meeting the educational needs of children and youth, these programs would play important roles in overall plans to maintain children at home.

Without direct administrative authority over local education agencies, MSDE can only promote these programs. Recognizing that this must be a long-term objective, the IPCC nevertheless recommends that in FY 1987, MSDE, with support from the other state agencies, intensify efforts to assist LEA's to develop this type of programming.

Objective: Expand other home and community services whose absence creates the most severe gaps in the continuum.

TASK #2: DHR through SSA, and DHMH through MRDDA, JSA and MHA, will develop an expansion plan for respite care, day care for special needs children, and personal care/parent aide services.

These services which directly assist parents to maintain special needs children in their homes are in short supply. To ensure their growth in the next three years, the two lead agencies, through the IPCC, will assess adequacy of resources in relation to need and present a plan to the IPCC by October 1, 1986.

TASK #3: DHMH, through MHA, should expand treatment staff, with specialities in child and adolescent mental health, in community mental health centers and increase outreach services to emotionally disturbed children and their families including home-based interventions.

The availability of mental health services for children and their families continues to be one of the most critical gaps in the continuum and is deemed a priority by all agencies. The lack of this service is frequently the missing link in State agencies' plans (particularly JSA's and SSA's) to maintain a child out of substitute care.

In the long term, the availability of these services must be expanded and DHMH/MHA is requested by the IPCC to indicate short- and long-range plans for the development of these services as part of budget planning for FY 1988. In the short term, increasing the availability of current services to SSA and JSA as part of their service plans for children may better target these community mental health services. Toward this goal, Task #4, below, will be pursued.

TASK #4: In FY 1987 local mental health centers will enter into agreements with local departments of social services and locally-based JSA intake, probation and after care units to make mental health consultation available.

Objective: Develop community-based service systems that better organize the diverse services needed to promote the growth and development of adolescents

TASK #5: DHMH, through JSA, should take the lead in developing a plan for the expansion of community-based programs for adolescents.

All agencies are seeing an increase in the incidence of "throwaway" children and an escalation in the seriousness of emotional, behavioral, and chemical dependence problems exhibited by adolescents. However, public services to this age group are particularly underdeveloped, and in many communities have no specific focal point. In part, this is because no State agency has lead responsibility for seeing that community services for adolescents evolve in a systematic way. By first providing a focal point for state planning and budget development for adolescents, State agencies can begin to address this problem (and the attendant scarcity of resources) directly. The IPCC has designated JSA as the lead agency to coordinate the development of a plan of community services for adolescents, with participation from SSA, MHA, MRDDA, ACA/DAA and MSDE. JSA's lead in this task does not imply a focus only on delinquent or pre-delinquent youth; the Plan will address broader populations of adolescents at risk. The schedule for completion of this task will be set by the IPCC.

Objective: Expand community-based services which prevent entry into foster care and other forms of substitute care.

TASK #6: DHR, through SSA, will continue to expand its family service programs in order to maintain children in their homes and communities rather than in foster care.

SSA's Intensive Family Services (IFS) program will be evaluated in FY 1986 as the basis for intended expansion in FY 1988. To assist families whose need for services is less acute than those served by IFS, SSA will also plan to expand its Continuing Protective Services program to achieve an appropriate worker/family ratio and its Services to Families with Children (SFC) program in order to assist its dysfunctional families before their difficulties with child-rearing become so severe that foster care is required. SSA's family services plans will be provided to the IPCC by July 1, 1986.

TASK #7: DHMH, through MRDDA, should expand the Family Support Services program in the jurisdictions now participating as well as to the remaining uncovered jurisdictions in the State.

While MRDDA's Family Support Services program is not solely for the purpose of preventing foster care, its goal of maintaining developmentally disabled children in their homes is essential to avoid unnecessary foster care where, once placed, developmentally disabled children often remain for long periods of time. Thus, if long-term substitute care is to be avoided, expansion of this community-based program is critical.

Objective: Establish a core service system to prevent adolescent pregnancy and to address the needs of teenage parents and their children.

TASK #8: DHR, through SSA and local departments of social services, will coordinate development of a core services system to prevent teenage pregnancy and assist adolescent parents, as called for by the report of the Governor's Task Force on Teen Pregnancy.

Core services are those which identify youth at risk, ensure access to services, and then provide case management services to link adolescents to the comprehensive array of health, educational, and social services needed to avoid unwanted pregnancies or to reduce the negative effects of such pregnancies for parents and children.

Objective: Expand adoption opportunities for special needs children to ensure permanent homes for these children.

TASK #9: DHR, through SSA and working in conjunction with MRDDA and the Developmental Disabilities Council, will explore adoption opportunities for special needs children with particular emphasis on minority children.

In FY 1987, SSA will expand adoption recruitment activities in private and public sector workplaces in the state, and will seek to increase recruitment activities in cooperation with minority churches and community organizations. By expanding community knowledge about the adoptability of special needs children, SSA will aim to increase the placement rate of special needs children even beyond the gains made in the past two years.

V. SUBSTITUTE CARE

Substitute care offers an alternative living situation, other than the home of the natural parent(s), adoptive parents or guardians, into which a child can be placed, when remaining at home is not in the best interest of the child. Substitute care includes emergency and shelter care, family foster care, and the more intensive residential services including residential treatment centers and psychiatric hospitalization.

Analysis of Current Programs

Maryland's substitute care programs (see Figure 6) have undergone marked change in the past ten years and will continue to change in the years to come.

Prior to the 1970's residential care, including both family foster care and institutional care, was the general treatment modality for special needs children. However, as described in the Introduction to this Plan, throughout the 1970's and continuing in recent years, the philosophy of appropriate treatment has changed and emphasis at both the national and state levels has been to keep children with their families.

This trend does not mean that substitute care programs have become a less critical part of the continuum, but that they should be used only when they are the most appropriate, least restrictive, form of care that meets a child's needs.

During the past 15 years there has been increased recognition of the specialized treatment needs of children and adolescents requiring institutional care. Hospital units specifically for the treatment of adolescents with severe and acute disorders have been developed, as have three residential treatment centers

Figure 6

V. SUBSTITUTE CARE SERVICES

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
A. Emergency and Shelter Care				
Emergency Shelter Care	DHMH/JSA	110 (adp)	statewide	$1,400,000
Runaway Youth	DHMH/JSA	645	3 jurisdictions	$200,000
Emergency and Shelter Care	DHR/SSA	129 (amc)	statewide	$590,000
B. Family Foster Care				
Individualized Family Placement (specialized family care)	DHMH/MRDDA	35	statewide	$167,00
Family Foster Care	DHMH/JSA	261	statewide	$309,000
Family Foster Care	DHR/SSA	5000 (amc)	statewide	$23,243,000
Family Foster Care (specialized or therapeutic homes)	DHR/SSA	893 (amc)	statewide	$2,900,00
C. Residential Services				
1. Alternative Living Unit (ALU) MR	DHMH/MRDDA	(see Small Residential Centers)	statewide	(see Small Residential Centers)
2. Group Homes	DHMH/MRDDA	(see Small Residential Centers)	statewide	(see Small Residential Centers)
Group Homes	DHMH/ACA/DAA	96	Metro Baltimore	$500,000
Group Homes	DHMH/MHA	20 beds	Central Maryland, Southern Maryland, Eastern Shore	$410,000
Group Homes	DHMH/JSA	159 (adp)	statewide access	$2,600,000
Group Homes	DHR/SSA	685[2]	statewide	$9,500,000[2]
3. Small Residential Centers				
MR and NRDD	DHMH/MRDDA	155	statewide	$1,580,000[3]
Maryland Youth Residence	DHMH/JSA	26 (adp)	statewide	$792,000
Purchase of Care	DHMH/JSA	152 (adp)	statewide	$2,832,000
Good Shepherd	DHMH/JSA	70 (adp)	statewide	$1,328,000
4. Non-Public Special Education Facilities[4]	MSDE/LEA's	685	statewide	$21,400,000[5]
5. Residential Treatment Centers				
State Residential Centers	DHMH/MRDDA	269	statewide	$9,300,000
Purchase of Care	DHMH/MRDDA	23	Central Maryland, Western Maryland, out of state	$404,800[6]
Residential Treatment for Chemical Dependence	DHMH/ACA/DAA	160	Allegany County, Dorchester County, (statewide access)	$520,000
RICA 1, 2, 3	DHMH/MHA	180 beds	3 jurisdictions (statewide access)	$7,773,000
Villa Maria	DHMH/MHA	80 beds	statewide access	$2,600,000
Residential Treatment	DHR/SSA	(see Group Homes)	statewide	(see Group Homes)
Purchase of Care	DHMH/JSA	47 (adp)	statewide	$1,260,000
6. Psychiatric Hospitals				
Psychiatric Hospitals	DHMH/MHA	379[7] (admissions)	statewide access	(included in facility budgets)
Purchase of Care	DHMH/JSA	8 (adp)	statewide	$80,000

SUBSTITUTE CARE SERVICES (continued)

SERVICES AND PROGRAMS	AGENCY	ESTIMATED NUMBER SERVED	GEOGRAPHIC AREA	ESTIMATED FUNDING[1]
7. Detention and Commitment Institutions				
Detention Only Institutions	DHMH/JSA	156 (adp)	statewide	$9,200,000
Youth Centers	DHMH/JSA	234 (adp)	statewide	$3,500,000
Hickey School	DHMH/JSA	430 (adp)	statewide	$11,200,000
Montrose School	DHMH/JSA	270 (adp)	statewide	$7,600,000

[1] *Total funds for FY 86 unless otherwise noted*
[2] *The estimated number served in group homes and residential treatment centers is combined here under group homes*
[3] *FY 85 funding*
[4] *This reflects Level VI special education services funded by state and local funds in approved non-public educational institutions*
[5] *FY 84 funding*
[6] *FY 85 funding*
[7] *Admissions of children and adolescents only*

(RICA's), to serve those children and adolescents who require long-term treatment for more chronic disorders.

One of the most significant alternatives in the substitute care system has been the development of the negotiated rates system, used by SSA and JSA as part of their purchase-of-care system. Under negotiated rates, a residential care facility's rates are negotiated based on the actual allowable costs of the facility, within cost guidelines set by the State. (SSA administers the system for both SSA and JSA, with an advisory group that includes private providers as well.) In FY 1987, the negotiated rates system is likely to achieve 100 percent of the allowable costs of care, thereby assuring providers of greater financial stability. In addition to providing fair rates for State-purchased care, the negotiated rates system is also designed to ensure quality care and to promote a care system that responds directly to the needs of children.

Just as the system of institutional care is changing, so is the system of foster family homes. Board rates for SSA foster family homes have increased by 25 percent in the past two years, accompanied by additional training requirements for foster parents. The Department of Human Resources' comprehensive plan for strengthening the foster care system, begun in FY 1986, has also included additional staff for local departments of social services, greater teamwork between foster care workers and foster parents, and the pilot testing of specialized or therapeutic foster homes for children whose needs are more severe than can be met in regular foster homes.

While the substitute care system is changing in response to the new requirements placed upon it, certain problems remain:

- The children who come into substitute care through SSA and JSA often have severe emotional disturbances, severe behavioral problems, or multiple problems and the range of substitute care services for these children is not yet available.
- There are small, but increasingly prominent special populations of children for whom appropriate substitute care resources simply do not exist. These include:
  - children who exhibit violent behaviors, i.e., children who injure themselves and others;
  - children with multiple handicapping conditions, particularly those with a combination of emotional and mental disorders, e.g., emotionally disturbed/retarded children;
  - severely handicapped children whose families can no longer physically care for them, and who need long-term care in a substitute placement;

- chemically dependent or chemically abusing adolescents; and
- the increasingly troubled children who are entering care on an emergency basis and for whom emergency and diagnostic care is lacking.

Priorities for Future Service Development

For those children for whom substitute care is the appropriate setting, the State has the responsibility to provide a high quality of care designed to meet their individual needs. Recognizing this responsibility, State agencies have begun several initiatives designed to upgrade the quality of institutional care. These include: the implementation of plans by MRDDA to improve programming, staffing, quality of care, environmental/physical conditions and to reduce the population at State Residential Centers (SRC's) as well as the plan by JSA to increase staff at Montrose and the Hickey School to provide better overall management, programming and oversight. In addition, as part of its recently announced plan for updating facilities, JSA is planning to provide up to 70 placements for committed youth at the Glen Mills School in Pennsylvania, a nationally recognized model for aggressive, "acting out" delinquent youth.

Beyond these actions, however, the State's goal must be to put in place the range of substitute care settings necessary to meet a child's needs when this level and intensity of care is appropriate.

Objective: Develop a wider range of residential care settings with emphasis on smaller, family-oriented and community-based settings.

TASK #1: DHMH, through MRDDA, will continue to implement the FY 1985-1994 Master Facilities Plan for deinstitutionalization by:

a. reducing the number of State Residential Center beds by 37 percent (2,621 to 1,664 available beds); and

b. increasing the number of available community beds from 1,675 at the beginning of FY 1985 to 4,549 by the end of FY 1994.

TASK #2: DHMH, through MHA, will establish four additional therapeutic group homes in FY 1986-87 with a total capacity of 10 homes by FY 1988.

TASK #3 DHMH, through JSA, will investigate the development of two additional youth centers (one may be on the Eastern Shore) to ease overcrowding at Montrose and the Hickey School.

TASK #4: DHMH, through JSA, will seek to increase funding for placements in small residential settings.

JSA's purchase-of-care budget has been unable to meet the needs of children for residential care in recent years. Due to funding limitations, some youth have been inappropriately maintained in JSA Commitment Institutions. To ensure that these children receive the care they need, JSA will seek to increase its funding for purchased placements by $1.3 million through FY 1988.

Objective: Increase the availability of emergency shelter and assessment/diagnostic services for children, particularly those coming into foster care.

TASK #5: DHMH, through SSA, will seek to expand beds in emergency shelter care facilities or emergency foster homes, with associated diagnostic and assessment facilities, by approximately 40 beds in FY 1987 and FY 1988.

Too often, the lack of these beds means that children coming into care are placed in regular foster homes which are unable to meet their needs. This can contribute to unnecessary multiple placements. The development of these beds should help ensure that children's needs are identified and that placement of a child — whether in a regular foster home, a residential care facility, or back with his or her parents — is the appropriate care setting for his or her needs.

TASK #6: DHMH, through JSA, should expand from four to five the number of Runaway Youth programs which provide temporary emergency shelter care.

The volume of need for these services requires at least one more facility and JSA will pursue the development of this facility as part of its overall development of community-based services.

Objective: Expand the range of available types of foster family care, in order to better respond to the diverse needs of children coming into care.

TASK #7: DHR, through SSA, will seek to expand the number of specialized or therapeutic foster homes to 60 beds by FY 1987.

This will build upon the experience of the pilot tests of alternative forms of foster family homes begun by SSA in FY 1986. It is estimated that at least 60 beds will be needed by the end of FY 1987.

TASK #8: DHR, through SSA, will take the lead with MRDDA and MHA in developing a multi-year strategy for more appropriate service for handicapped children requiring long-term care, but who are not appropriate for the current foster care system and who have no other avenue for service.

The strategy should include: analysis of the number of children with actual/potential need; identification of MRDDA's capacity to serve these children in their own homes; and development of a joint DHR/DHMH pilot project to provide funding for these children as part of a long-term specialized care program.

Objective: Continue to develop in-state resources for children who now must be placed out of state because there is no appropriate Maryland facility which meets their needs.

TASK #9: The State Coordinating Council for the Residential Placement of Handicapped Children (SCC) will identify common needs filled by out-of-state placements that could support alternative in-state programs.

The Interagency Planning Committee for Children will then assign lead responsibility to an agency to develop plans for a range of in-state residential alternatives for these children. It is intended that SSA, JSA, MRDDA, MHA, and MDSE develop coordinated budget requests to provide necessary start-up funds for these programs. (Alternative funding options such as those available through the Department of Economic and Community Development will also be investigated).

Objective: Increase the range of specialized short term residential services, as necessary, to meet the mental health needs of children.

TASK #10: DHMH, through MHA, should — by August 31, 1986, — take the lead in developing a plan for bed expansion to accommodate the needs of emotionally disturbed children 12 years old and under with priority given to in-patient care under 90 days.

TASK #11: DHMH, with JSA as the lead agency and with support from MHA and DHR/SSA, will develop a residential treatment program for children on the Eastern Shore.

Planning for this facility is well underway. With collaborative support and funding from JSA, MHA and SSA, this program is scheduled to begin operation in FY 1987.

In addition to these objectives, the IPCC identified other priorities for resource development which will be a focus of planning in the year ahead. These include the development of both short-term residential treatment programs and group home programs for chemically dependent youth. The IPCC has identified the severe lack of these services as a problem, but additional planning is needed before specific objectives are set in these areas.

INTERAGENCY ISSUES IN MANAGING THE CONTINUUM OF CHILDREN'S SERVICES

The preceding sections of the Plan identify the continuum of services and priorities for future development. Expansion of service by itself, however, will not result in the well-coordinated system of services that is sought. In addition, it is necessary to resolve key issues of service planning, management, and delivery which affect all children's services.

For this section of the Plan, the State agencies examined eight "cross-cutting" administrative or service delivery issues. For each, options were considered and recommendations made about how best to address the issue so as to improve services to children and families. The plans of action relate to each of the issues listed below:

- Uncovered Children
- Ongoing Long-Range Planning; Joint Budgeting and Funding
- Service Planning and Case Management
- Community Education Regarding the Availability of Services for Special Needs Children
- Coordinated Interface with Private Sector Providers
- Transitioning Services
- Interagency Licensing and Monitoring
- Interagency Rate Setting

UNCOVERED CHILDREN

Issues

There are many special needs children who receive inappropriate or no services. This is due to the fact that there is often confusion as to which agency should be responsible for planning, budgeting and developing programs for these populations. What planning procedures need to be established to ensure coverage of these important groups?

Background and Analysis

Pursuant to federal and state law, Maryland defines each agency's target population and responsibility primarily by the nature of the client's problem. This approach makes agency responsibility dependent on the diagnostic labels attached to children's problems. For example, local departments of education under P.L. 94-142, the Education for All Handicapped Children Act, are responsible for children labeled "seriously emotionally disturbed," but not for those labeled "socially maladjusted." A problem arises because many children do not fit neatly within one of the categories for which agency responsibility is clearly defined, but instead have multiple problems. In addition, for some of these children, there is no clear federal or state mandate for service and agencies with scarce resources are reluctant to assume responsibility.

There are several such groups of children for whom no single agency assumes responsibility for a service. Examples of these types of children are as follows:

- The youngster whose emotional disturbance leads to extremely violent behavior. (Is JSA or MHA responsible?)

- The dual-diagnosed or multiple-diagnosed youngster (e.g., a child who is mentally retarded and who also has cerebral palsy and mental health problems).
- The special needs child whose behavior is socially unacceptable and whose home situation is less than satisfactory. For example, many children who run away from home or are ungovernable (CINS) have family problems and could also be labeled as CINA. As the JSA 1980-84 plan states:

  "Another problem facing JSA relates to the type of juvenile the Administration is beginning to receive. Current experience indicates that Juvenile Services is getting more disturbed youth referred for community-based placement than in the past. Because these youngsters are aggressive and assaultive, cannot function in a public school setting and run away, they are more difficult to maintain in the community and require treatment services beyond the scope of many of the facilities within the State of Maryland. These youngsters could more appropriately be labeled as Children in Need of Assistance (CINA), but because of the scarcity of resources and their technical involvement with delinquent-type behavior, they're being adjudicated to be CINS or Delinquent. The problem is there is no single agency that is capable of providing the services that this group of youngsters needs." (JSA 1980-84 Plan at V-638)

- The child who, while not meeting the criteria for being determined "educationally handicapped," nevertheless has special needs. For example, the child who has a 70-90 I.Q. and is culturally deprived or the socially maladjusted youngster, as described in the JSA 1980-84 plan:

  "Another group of youngsters requiring services is the inner city/urban type youth with social and cultural problems. Their unique problems make it difficult for these youngsters to utilize public school settings. In many cases, they are accurately referred to as 'disruptive youth.' Since they do not technically meet the criteria for special education — only a few school systems have specific programs for disruptive youth (e.g., 'alternative schools') — these youngsters are often suspended or expelled from public school. Their subsequent referral to the Juvenile Court, and placement on probation/protective supervision raises serious questions when an educational program is not available for these youngsters. The resolution in many cases is to remove the youth from school and assist him or her to enter the labor market where teenagers already represent the greatest percentage of unemployment." (JSA 1980-84 Plan at V-632)

- The handicapped youngster whose parents are unable to provide residential care and for whom long-term care is needed. Either DHR or MRDDA or MHA could be responsible for this youngster.

Recommendations

The State's goal for these groups of children must be to clearly affix the responsibility for: identifying the extent of need of each population; planning the necessary services; budgeting the necessary resources; and otherwise taking the leadership role — often with support from the specialized services of other

agencies — in ensuring that appropriate services are developed. To achieve this end, the following will be done:

1. DHMH, through the Assistant Secretary for Mental Health, Mental Retardation, Addictions and Developmental Disabilities, will convene a working group by March 1, 1986 consisting of two representatives (one program and one finance person) from DHR/SSA, MSDE, DHMH/MRDDA, DHMH/MHA, ACA/DAA, DHMH/JSA and from advocacy groups.
2. The working group will develop a plan by July 31, 1986 for the Interagency Planning Committee for Children which will:
   - identify the needs of the unserved populations listed above and determine which agency will be designated as responsible for providing the continuum of services for each of the unserved populations; and
   - determine the cost of providing services and include in the budget requests for FY 1988 money to begin providing appropriate services to these populations.

ONGOING LONG RANGE PLANNING; JOINT BUDGETING AND FUNDING

Issues

How can coordinated, short- and long-term planning for children with special needs continue to promote a well-developed and financed continuum of service?

How can funding resources among agencies be maximized to ensure needed services to children who are in out-of-home placements?

To what extent should agencies be able to move funding among budget categories to meet the specific needs of children and to promote in-home and community-based care?

Background and Analysis

Although significant progress has been made, there continues to be a need for increased coordinated planning and budgeting on behalf of special needs children. Because agencies have developed services based on specific legal mandates, each agency's program necessarily focuses on those mandates and the funding provided to carry them out. In addition, each agency is involved in its own planning processes, generally to meet federal or state requirements. However, many children with special needs require services from multiple agencies.

When each agency plans only for its own services, such a process can lead potentially to a duplication of services, as well as a loss of coordination among agencies. Such planning also risks focusing on particular problems, rather than on the needs of the whole child.

One area that the IPCC identified as a high priority for continued planning is the concept of "dollars following the child." Current budgeting processes do not allow for movement of funding across budget categories to accommodate a particular child's needs. For example, if a child is receiving Level VI special education services, those funds by state law cannot be used to provide a less

expensive and possibly more appropriate day education experience. Similarly, if funds are used to provide institutional services, such as those provided by JSA, it is currently not possible to redeploy those funds to provide a different level of care, such as a group home. Also, if funds are budgeted for group homes, it is not possible to redeploy those dollars back to the family in order to provide community support services to enable the child to remain with his or her family. Funding is further limited by the source of funds (state or local). Funds do not follow children and adolescents from local government to state programs or private programs. For example, funds used to provide special education services in a local school system do not follow a child if he or she is later placed in a state residential program or group home in another county. The child's special education needs are the same, but the funds remain in the locality of residence.

Recommendations

1. **To ensure that services are focused on the whole child and not just on specific aspects of a child's problem and, further, to ensure an adequately funded continuum of care for special needs children, interagency planning and budgeting for these children should become an ongoing function of State government. An Interagency Planning Committee for Children (IPCC) will be established for this purpose. DHR will convene and chair this effort in FY 1987, as it did in FY 1986, at the Governor's request. Participating agencies will include JSA, ACA/DAA, MHA, MRDDA, and PMA from DHMH; MSDE; the Governor's Office for Children and Youth (OCY); and the State Coordinating Council (SCC). A major task of this group will be to update this *Interagency Plan for Children with Special Needs* and to monitor implementation of the recommendations contained therein.**
2. **To ensure that more local input is obtained for planning in the coming year, the IPCC will expand its membership to include local agency representatives. In addition, plans and proposals developed by the IPCC will be sent for review to local counterpart agencies whenever appropriate.**
3. **The IPCC will explore the feasibility of duplicating the IPCC planning process at the local level. The Governor's Office for Children and Youth will analyze the alternatives for supporting such local planning efforts in the context of already ongoing efforts. The Governor's Office for Children and Youth will make recommendations to the IPCC on the development of local planning initiatives by July 1, 1986.**
4. **To provide a focus for children's programs within DHMH, a Children's Coordinator for DHMH programs should be established in the Secretary's office, or at a level in the Department that allows coordination across program units. This coordinator could assist in providing consistent policies across DHMH administrations regarding rate setting, licensing, service coordination, joint funding, and similar issues that affect children.**
5. **As part of the IPCC process, and in order to maximize available funding, SSA, JSA, MRDDA, ACA/DAA, MHA, PMA and MSDE will share budget information and develop joint budget requests as appropriate. This will include discussions early in the budget process (before budgets are formulated) on both existing programs and planned initiatives as well as ongoing discussions throughout the various stages of the budget process.**

6. **To maximize the availability of funding among budget categories, the IPCC will explore the potential of client-specific funding (i.e., funding which follows the child) and include a proposal for consideration in the next annual Plan.**
7. **To ensure the coordination of services among agencies and to maximize funding, the IPC should consider the further use of "funding pools" such as are currently being used to fund the SCC and therapeutic group homes.**
8. **To maximize available funding for community-based services, DHMH through Medical Assistance and the Mental Hygiene Administration, will work with the federal government to secure the under-21 Medicaid option which will provide federal funding for residential treatment centers and inpatient psychiatric care for children and adolescents. Securing these federal funds has the potential to "free up" general funds which could then be used to expand to community-based programs such as therapeutic group homes, community mental health services, respite care, specialized foster care, etc. for children, adolescents and their families.**

SERVICE PLANNING AND CASE MANAGEMENT

Issues

How can effective service planning and case management be ensured for the multiple services required by special needs children?

Background and Analysis

Case management is a critical component for the effective provision of services to children with special needs because many of these children require the services of more than one agency. Case management refers to a process that provides for: (1) assessing individual needs; (2) developing an interdisciplinary plan for services that meet these needs; (3) securing needed programs and services to implement the plan; (4) reassessing the service plan on a regular basis; and (5) monitoring the quality of services provided to the child and family. Inherent in a system of case-managed services is the goal of integrating services to prevent duplication of effort and resources.

Case management services are provided in a variety of ways both within and among agencies:

- While the *Maryland State Department of Education (MSDE)* does not provide case management services per se, an Individualized Education Plan (IEP) is developed for each child who is in need of special education services.
- *Juvenile Services Administration (JSA)* is mandated to provide case management by the Courts and Judicial Proceedings Article. Youth served are those adjudicated either as a "Child in Need of Supervison" (CINS) or Delinquent and placed under the supervision of JSA. Proposed regulations, policies, and procedures regarding intake, probation and after-care/case management exist. To clarify case management responsibilities for JSA children who are also receiving services from other agencies, JSA has entered into a joint services agreement with the Mental Hygiene Administration (MHA) and a memorandum of understanding with the Social Services Administration (SSA).

- *The Social Services Administration (SSA)*, though local departments of social services, provides case management in most of its service programs for families and children. Caseworkers develop a plan of care that is the basis for actions taken on behalf of a child or family, and perform periodic reassessments of this plan. Requirements for service planning are being specified in regulations and policy manuals.
- While the *Mental Retardation and Developmental Disabilities Administration (MRDDA)* has no legal mandate for case management and no centralized point of access, it does provide services to designated individuals through local health departments, state residential centers, regional offices, and private not-for-profit agencies. The MRDDA has proposed "Services Coordination" regulations that are not yet promulgated; these will also help clarify responsibilities when multiple agencies are involved.
- The *Alcoholism Control and Drug Abuse Administrations (ACA/DAA)* are not mandated to provide case management services; however, they do have intake/assessment units located in health departments in all counties and Baltimore City.
- Case managers are assigned for all individuals in *Mental Hygiene Administration Programs*. This assignment is specified in COMAR 10.21.05, "Outpatient Community Mental Health and Community Rehabilitation Programs."

As is clear, the degree of systematic service planning and case management for a special needs child will vary depending upon the service system the child enters. However, the most serious problems occur when a child has multiple impairments, needs multiple services, and the designation of a lead agency is neither immediately obvious nor clear.

Recommendations

1. **Case management and clear service planning should be an integral part of every agency's service delivery system. When a child is the particular responsibility of an individual agency, that agency should be accountable for case management and should assist the child in securing needed services from another agency (e.g., a child with mental retardation in need of specialized foster care).**
2. **To guarantee a common understanding of agencies' mutual responsibilities in the case management process, interagency agreements will be developed which (1) establish criteria for referrals; (2) identify when each agency will take the lead case management role for particular children; and (3) state how each agency will cooperate with the agency having the lead case management role. Interagency agreements should be developed with local input and participation, so that they resolve the most pressing service delivery problems.**

Priorities and timelines for the development of interagency agreements are as follows:

- An interagency agreement between SSA and MHA for the provision of mental health, diagnostic, assessment, and treatment services for foster children by August 31, 1986.
- An interagency agreement between SSA, MRDDA and MHA for the provision of therapeutic services for children in specialized foster homes by July 1, 1986.

COMMUNITY EDUCATION REGARDING THE AVAILABILITY OF SERVICES FOR SPECIAL NEEDS CHILDREN

Issues

In what ways can the system of services for special needs children be more accessible to those in need?

Background and Analysis

The availability of services to special needs children represents a paradox. On the one hand, services are in short supply and, as noted earlier in this Plan, the continuum of services does not fully exist. On the other hand, the sheer number of discrete services and programs available, both at the State level and in local jurisdictions, for special needs children can make access to these services confusing for families in need. There is no common point of entry for all service systems. Parents may attempt to obtain services by going first to a private physician, a local health center, a specialized health facility such as the Kennedy Institute, a local department of social services, and/or local schools, as well as many other agencies.

In addition, service availability varies by geographic location within the State. Rules for system access may vary from agency to agency and locality to locality. Client needs may even be defined differently in different jurisdictions. Eligibility criteria and policies which impact this population are frequently complex. When added to the need for parents to interact with several agencies, the task of securing needed services can seem a formidable one.

A final barrier to full use of services by special needs children is that receipt of services may be influenced by the income level of the family. Parents in the highest income and education groups are most knowledgeable about their rights, the child's rights, and available services. Those in lower income groups are less aware of the same services which may be available to them. For the State, the task is to equalize access to services through effective community and parent education.

Recommendations

1. **To ensure that every child in the State, regardless of where he or she lives, has equal access to services, the Governor's Office for Children and Youth as the lead agency in conjunction with DHR, DHMH and MSDE, will define a minimum service base which is to be provided in each jurisdiction. This minimum service base should include basic health services, social services, and educational services, as well as access to substitute care and other specialized services. A report describing the geographic availability of services will be presented to the IPCC by January 1, 1987.**
2. **To ensure that families of special needs children are aware of the services available to them and their right to receive these services, public information and advertising regarding available services should be greatly increased. The Governor's Office for Children and Youth in its coordinating role will take lead responsibility for this effort in cooperation and collaboration with the agencies which provide the services. A report to the IPCC of expanded public awareness efforts is expected by October 1, 1986.**
3. **To ensure that agency professionals are aware of the various social, educational, medical, and other resources available throughout the State, a strong system of resource coordination among Departments and**

agencies will be developed. This includes establishing a system of "experts" to serve as consultants in each region or locality for each agency. These experts or consultants should have special training in the services, mandates, and funding of other agencies and would meet periodically to exchange information. This system will have to be developed within the staff constraints of local agencies. DHR through SSA, will take the lead in assessing the feasibility of this network and in submitting a plan for its implementation to the IPCC by October 1, 1986, with implementation to be accomplished by January 1, 1987.

COORDINATED INTERFACE WITH PRIVATE SECTOR PROVIDERS

Issues

What role should private providers play in the development of Department budgets and program directions?

Background and Analysis

Implementation of the continuum of services requires a coordinated and cooperative effort between the public and private sectors. The public agencies rely on private agencies to provide many types of in-home and community services as well as substitute care (group homes, small residential centers, foster homes). The private sector, in turn, increasingly relies on public funds to support operations. While both sectors have shared as well as unique views of how services should operate, program priorities should be established with mutual understanding of future directions. To achieve this goal, public and private agencies need to be involved in planning for special needs children.

Recommendations

1. **Since the private sector provides many different services to children with special needs, it is essential they be involved in the planning and have input into budgetary priorities for these services. Private provider representation on the IPCC is critical.**
2. **Public agencies which purchase care must work more directly with private providers to identify (1) future publicly-funded service priorities, (2) the level and volume of service that a public agency will be purchasing from providers, (3) the need for program changes within a specific provider or a group of providers. This will allow providers as a group to identify clearly the role that each will play within the service continuum, and to anticipate funding levels associated with the service they provide. The IPCC further recommends that in FY 1986-87, the State agencies link specifically with several providers of substitute care whose programs are changing to develop longer-term program plans that give clear directions and financial stability for these new programs.**

TRANSITIONING SERVICES

Issues

In what ways can State agencies which plan and operate programs for adolescents with special needs ensure that these youth have a planned transition either into independent adult lives or into other adult service systems?

Background and Analysis

Until recent years there was little attention given by the social services and special education systems to children who were "aging out" of their systems. A youth who became 18 or 21 in the educational system was required to negotiate a new set of services and supports. Little preparation was given by school programs for independent living or for gaining access to needed adult services. Similarly, service programs such as the State foster care program have not always prepared children for assuming adult responsibilities. As children in foster care are increasingly more seriously disturbed, their preparation for independent living, or for transitioning to adult protected living situations, must become an essential part of the service system.

The difficulties faced by special needs children moving into adulthood vary for different population groups. Children diagnosed as mentally retarded, who have actively participated in special education programs, must face long waiting lists for transition into MRDDA Day Programs; they often regress during this period. Some foster children with handicapping conditions are ill-equipped to earn a living and face the prospect of dependency or institutionalization as adults.

In summary, the transition from childhood to adulthood, a difficult step for any child, is especially difficult for special needs children.

Recognizing the importance of "transitioning," agencies have developed several programs or services to aid the populations they serve.

The *Maryland State Department of Education* is engaged in activities to improve the coordination of transition services for disabled youth leaving school and entering the world of work. Currently, there is a cooperative agreement involving three major education divisions: Special Education; Vocational Rehabilitation; and Vocational-Technical Education. This agreement provides a framework for local education agencies cooperatively to provide skilled training services to youth and genuine transition assistance as they leave educational programs. Local education agencies now provide handicapped students with individual transition services in accordance with House Joint Resolution No. 40, passed during the 1985 session of the General Assembly.

MSDE also has received several federal grants to help develop transitional support services for the deaf-blind population, and to implement in-service telecourses (television instruction). These are designed for staff at the state and local level in order to facilitate the delivery of services to students in the transition process. The Division of Vocational Rehabilitation, working cooperatively with other state agencies, private service providers, and other non-profit organizations and advocacy groups, will be expanding supported employment opportunities for the severely disabled.

Future activities identified for FY 1986 include the preparation of a position paper on the role of the Maryland State Department of Education in the transition process; the reinforcing of education agencies' cooperative agreements at the state and local levels; and the development of a guide to assist in clarifying the roles of service providers in the transition process. Concurrent with the development of these materials is the provision of State Education Agency technical assistance to local education agencies.

In 1985 the DHMH *Mental Retardation and Developmental Disabilities Administration* and the Maryland State Department of Education, Division of Special Education have cooperatively implemented the Student Adult Services Survey (SASS) to assist the MRDDA in gathering information concerning students in special education, from 18 to 21 years of age, who will be leaving the school system and entering the adult service system. Information collected includes demographic, functional, and service needs.

The MRDDA also became involved in 1985 with Project TIE (Transition Into Employment) along with the Maryland State Department of Education, Divisions

of Special Education and Vocational Rehabilitation. The purpose of Project TIE is to bring together individuals who provide school and post-school services to individuals with severe handicaps so that transitioning from school to supported competitive employment is accomplished in an organized and effective manner. The overall goal of the Project TIE effort is to enable students to make the transition into active employment as opposed to work activity centers, sheltered workshops or adult day programs where little movement is realized.

The *Social Services Administration* is giving priority to independent living and transitioning services in its planning and budgeting for older children in foster care. To ensure that adolescents who are "aging-out" of foster care are prepared for adult responsibilities will require three types of activities. First, foster care staff and foster parents will receive additional training related to preparing older foster children for independence. Second, SSA hopes to make available purchase-of-service dollars so that foster care staff in local departments of social services can buy from community agencies a range of training, employment counseling, motivational counseling, and similar services that can prepare adolescents for independence. Finally, SSA plans to test, through one or more demonstration projects, intensive support services for older foster children with special needs who otherwise could not achieve independence.

The Juvenile Services Administration has no specific programs for transitioning but includes this activity as part of the established counseling and referral process. Referral is made to local departments of social services, as needed, for adult services.

Recommendations

1. **Through the IPCC, MSDE should assume the lead in ensuring that information on transitioning services for special needs children is communicated regularly among the agencies; that the various plans under development are coordinated; and that joint budgeting of transitioning activities occurs where these services are directed to similar populations.**
2. **MRDDA, with assistance from MHA and SSA's Adult Services Division, should make available to local agencies serving special needs children (particularly local education agencies) information on State-supported housing arrangements for disabled adults. These include housing arrangements for mentally retarded and other developmentally disabled individuals; chronically mentally ill individuals; and other disabled adults. This information should be compiled and made available by June 1, 1986.**

INTERAGENCY LICENSING AND MONITORING

Issues

To what extent should agencies coordinate licensing and monitoring activities for residential child care facilities?

To what extent is the licensing/monitoring of residential child care facilities adequately performed?

Background and Analysis

The purpose of licensing residential child care facilities is to provide a minimum set of standards which all programs must meet in order to ensure the physical, social and emotional well-being of the children who are placed there.

Currently, however, different State agencies take different approaches to licensing and utilize different standards, as described below.

- *The Social Services Administration (SSA)* licenses facilities as group homes and child care institutions. In its new regulations, SSA is using an approach which defines core, minimum standards for health and safety that all residential facilities must meet. In addition, "modules" are being specified which establish licensing requirements in addition to the core standards. The modules include standards for: shelter care; residential care; secure care; maternity homes; and temporary or transitional education. SSA licenses 49 in-state group care facilities, participates in the licensing of five in-state residential treatment centers, and monitors 25 out-of-state facilities.

In the Department of Health and Mental Hygiene (DHMH), several agencies are involved in the licensing of residential child care facilities.

- *The Juvenile Services Administration (JSA)* licenses 32 facilities in categories similar to SSA's (although the terms used to describe these facilities are different). JSA has worked jointly with SSA in the development of the core standards/module approach. In the future, JSA/SSA regulations for the licensing of residential facilities will be similar or identical.
- *DHMH's Licensing and Certification Division* licenses residential treatment facilities and hospitals as well as some facilities which serve the developmentally disabled.
- *The Mental Hygiene Administration (MHA)* does not actually license facilities for children and adults, but does certify the program component of the therapeutic group homes.
- *The Alcohol Control and Drug Abuse Administrations* promulgate standards to be used in the certification of residential programs which specialize in the treatment of chemical abuse.
- *The Mental Retardation and Developmental Disabilities Administration (MRDDA)* licenses day programs, and group homes. It also certifies Alternative Living Units (ALU) and agencies that provide services coordination programs.
- *The Maryland State Department of Education* has certification and accreditation procedures which are applied to educational programs in residential facilities; and, with SSA and JSA, is developing standards for educational programs that are transitional in nature, helping children in residential facilities to return to public schools (proposed regulations under development).

Several problems are associated with this diversity of approaches to licensing regulations:

- The standards vary across agencies, with no one consistent approach to either health and safety issues or program standards.
- There is no mechanism for the consistent interchange of information regarding regulatory changes or needs.
- Some licensing regulations are out-of-date or require revisions.
- There is no requirement that State-operated facilities meet the same standards as private facilities.
- The number of state level staff available to monitor, evaluate, regulate and assist licensed facilities or applicants is insufficient.

SSA and JSA have developed an approach to licensing which may hold promise as the nucleus of a uniform state approach to licensing residential child care facilities. This approach includes joint review and evaluation, using common guidelines, of those facilities where both agencies place children.

Recommendations

1. **To ensure better coordination of existing licensing activities, an interagency workshop composed of representatives from the licensing staffs of SSA, JSA, MRDDA, DHMH Licensing and Certification, and MSDE should: meet quarterly to exchange information on licensing needs and programmatic developments; work toward comparability in core licensing standards that could be used by each agency; and identify specific instances of licensing regulations that require strengthening. The meetings should be convened by SSA and reports submitted to the Directors of each agency and the IPCC.**
2. **Specific areas of State licensing policy should be strengthened or developed into regulations by the responsible agencies. These include:**
   - **updating of residential treatment center regulations, focusing on expansion of program content (DHMH Licensing and Certification);**
   - **updating regulations on transitional educational programs (SSA, JSA and MSDE); and**
   - **establishing the currently proposed guidelines on sanitation and physical hazards as regulations which would apply uniformly to all agencies licensed by SSA, JSA or approved by MSDE.**
3. **To ensure a consistent approach to licensing regulations between agencies, certain minimum standards should be adopted with additional program content reflected in the regulations for each category of facility. Also, certain priority areas of program content should be similar or identical in all regulations. Specifically, the child abuse prevention reporting and investigation requirements should be uniform as specified in the recommendations of the Child Protection Review Panel.**
4. **To ensure adequate and timely licensing and monitoring of facilities, each agency should assess the adequacy of licensing resources and identify the need for additional staff or staff training. Criteria for assessment should include frequency of monitoring visits and frequency and nature of relicensing activities.**
5. **To ensure equal protection for children among public and private facilities which are providing essentially similar services, public facilities should be required to meet the same licensing requirements as the private facilities (SSA and JSA).**

INTERAGENCY RATE SETTING

Issues

In what ways can agencies collaborate in establishing rates for residential child care programs?

Background and Analysis

Agencies use different methods to establish rates for residential programs in which they purchase care.

- *SSA and JSA* use the negotiated rates system, through which each facility's rate is established based on a budgetary review of actual costs against allowable cost guidelines. Rates are set with input from an Advisory Committee composed of public and private agency representatives. The benefit of this type of system is that rates paid by SSA and JSA are consistent, fairly determined, and permit state and private agencies to meet the changing needs of the institutional populations in a planned structural way.
- *MRDDA* negotiates contracts on an as-needed basis for residential child care. The rate fluctuates according to the type of services offered. MRDDA proposes to replace the current system of lump sum grant awards with a cost-related reimbursement system driven by client needs and vendor characteristics. The proposed system in MRDDA is an attempt to move from retrospective rate setting with year-end adjustments to prospective payments based on formula rates.
- *MSDE* negotiates with non-public providers after they have provided detailed cost statements for each facility. The Local Education Agency (LEA) pays up to 300 percent of the LEA's average per pupil cost for educational expenses; MSDE supplements all State-approved cases for costs above the local contribution.

With the exception of SSA and JSA, which have worked together in establishing the negotiated rates system, there is no standardized approach for establishing rates to pay for residential child care. This lack of an equal rate structure can impose hardships on residential facilities where purchase of care is made by different agencies, with different rates. Where lower payments are made by one agency, the burden of meeting costs is left to the child care facility and to other child placement agencies.

The problem of inadequate rates for care has been addressed by the negotiated rates system. SSA/JSA have increased their rates steadily, and in FY 1987 are likely to achieve 100 percent reimbursement of allowable costs. This standard of meeting the allowable costs should be maintained as new types of placements, such as therapeutic group homes or emergency shelter care, are developed or expanded.

Recommendations

1. **To establish comparable reimbursement among all agencies placing children with special needs, a common approach to rate setting should be established. This approach should be based on the following principles:**
   - **negotiation of rate based on actual cost;**
   - **use of cost guidelines established for various cost items or services; and**
   - **commitment to reimburse at or close to full costs.**

2. **For facilities where more than one agency places children, the payment rate should be uniform.**

APPENDICES

HANDICAPPED CHILDREN

Appendix A

As defined by the Maryland State Department of Education in the Code of Maryland Regulations 13 A.05.01

"Handicapped children," includes those children who have been described as follows:

"Deaf" means a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects educational performance.

"Deaf-blind" means concomitant hearing and visual impairments, the combination of which causes so severe communication and other developmental and educational problems that the child cannot be accommodated in special education programs solely for deaf or blind children.

"Hard of hearing" means a hearing impairment, whether permanent or fluctuating, which adversely affects a child's educational performance, but which is not included under the definition of "deaf."

"Mentally retarded" means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child's educational performance.

"Multi-handicapped" means concomitant impairments (such as mentally retarded-blind, mentally retarded-orthopedically impaired, etc.), the combination of which causes such severe educational problems that the child cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blind children.

"Orthopedically impaired" means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes: impairments caused by congenital anomaly (for example, clubfoot, absence of some member, etc.); impairments caused by disease (for example, poliomyelitis, bone tuberculosis, etc.); and impairments from other causes (for example, cerebral palsy, amputations, and fractures or burns which cause contractures).

"Other health impaired" means limited strength, vitality, or alertness, due to chronic or acute health problems (such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes), which adversely affects a child's educational performance.

"Seriously emotionally disturbed" means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance: an inability to learn which cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.

SERVICE DEFINITIONS

I. Primary Prevention Activities

Those services that seek to anticipate the occurrence of problems (physical, social and/or emotional) and act to prevent them.

Community Education Services which promote and endeavor to maintain physical and mental health through the provision of information to the general public as well as to special segments of the population. The purpose of these services is to stimulate public awareness of and reponsiveness to physical and mental health concerns.

Primary Health Care Basic level health care, generally rendered by general practitioners, family practitioners, internists, obstetricians, pediatricians and more recently by mid-level practitioners. This type of care emphasizes caring for the patients general health needs as opposed to a more specialized or fragmented approach to medical care. This care is usually rendered in an out-patient setting.

II. Early Intervention Services

Those services which provide early identification, assessment and prompt services in order to shorten the duration of the illness or problem. In terms of this plan, it means involvement with the child or adolescent after the problem has surfaced but before it escalates.

Information and Referral A service which provides basic information on a specific topic and includes formal or informal referral to a service provider with expertise in the specific area. This service may also include a preliminary/brief diagnosis of the problem. This service may include hotline and telephone messages which provide telephone coverage by persons trained to handle specific problems, usually of a crisis nature. Telephone messages are special phone services providing recorded information on specific topics.

Programs to Identify and Prevent Developmental Problems in At-Risk Children Services which are designed to detect non-communicable health-related conditions and impairments. Programs include screening of infants, school children, and pre-school children as well as specifically defined at-risk populations.

Parent Education or Other Parent Support Programs Services to parents, guardians, custodians or prospective parents aimed at enhancing parenting skills and assisting in maintaining a stable family unit.

III. Evaluation, Assessment and Diagnosis Services

Evaluation means a full range of assessments completed by qualified examiners to help diagnose problems and concerns relating to an educational handicapped condition, medical or health disability, developmental disability, or psychological/mental health problem.

The results of the assessment(s), which must be administered by a properly trained qualified examiner, should be used to assist in focusing on the individual child's total needs. Evaluation services, as described above, are available through local agencies and departments that serve each jurisdiction in the State.

IV. In-Home and Community Services

Those services provided to a child who is living at home. Such services are designed to support a family living situation and to prevent institutionalization or to support a child and that child's family after the child returns home from a residential program.

Family and Individual Counseling A service which uses counseling methods that assist individuals and families who are in the process of identification and analysis of their problems and the exploration of alternative resolutions as well as the adoption of a positive course of action. Such counseling may be on a one-to-one or group basis.

Outpatient Psychiatric Therapy A service focusing on the provision of diagnosis and/or treatment of individual mental or emotional problems that do not require 24-hour confinement. Services are oriented toward providing the maximum recovery level for an individual's well being.

Respite Care A service which provides temporary relief to individuals responsible for the constant care and supervision of physically and/or mentally handicapped persons. These services may be provided in a family home or in facilities outside the home.

Day Education/Treatment Programs Special education opportunities for individuals having physical, mental, and/or emotional and/or social adjustment handicaps which permit educational development at a pace and to the level permitted by the individual's limitation. This includes: Level I-V Special Education Services in Public Schools which focus on providing special education to handicapped students in a public school day program; and Level V Special Education Sevices in approved Non-public School and State Operated Programs (day program). This may also include early childhood special education, a program which focuses on providing meaningful and appropriate educational experiences to pre-school children who because of some handicapping condition, are not likely to benefit as much as non-handicapped children from regular pre-school experiences.

Recreation/Social Programs This service focuses on contributing to individual, family and community well-being by providing opportunities for physical and social development through the use of recreation on a participatory or spectator basis.

Personal Care Provision of in-home aide service to perform specific tasks which the family is unable to perform for itself. This would include tasks such as household management, in-home child care, shopping, etc.

Day Care Provision of assistance to the family unit by making available care protection, supervision, developmental opportunities, and guidance for children. The programs may be family-based or center-based and offered on a part-time or full day basis. This service also includes Before and After School Care.

Specialized Equipment and Housing Adaptations Special devices (e.g., tub chairs, feeding pumps) or modifications to the architectural structure of a home that allow for increased accessibility and assist the disabled child/adolescent to function more independently.

Transportation This service makes available and accessible the resources of the community from which handicapped children would otherwise be isolated. Such programs make it possible for them to gain access to various service programs.

Vocational Education and Transitioning Programs Assists individuals to adequately prepare for paid employment and directs them to areas of employment activity.

Tutoring Provides educational assistance to children who are having difficulty in school or who are unable to attend school due to mental or physical disability. This service is usually provided on an individual basis.

Specialized Medical Services Services provided by physicians or allied health professionals to ameliorate or stabilize a health-related condition or impairment that may hinder achievement of normal growth and development. Services include but are not limited to consultation in specialty clinics, in-patient hospital care, as well as speech, audiology/hearing, physical, and occupational therapy.

Self-Help Services Groups of individuals who join together to share their strengths, hopes, and experiences with each other in order to encourage and enhance their recovery from a common problem. The most notable self-help organization is Alcoholics Anonymous. Similar self-help organizations include Narcotics Anonymous, Alanon and Parents Anonymous. These groups are autonomous, fully self-supporting, and available to anyone who feels he or she may have a problem in the areas described.

Volunteers Volunteers are individuals who donate their time to work with persons or groups of persons who have medical, emotional, social or addictive problems, and/or who have committed adult or juvenile justice offenses. Volunteers might be professional or lay individuals who work with community programs or within institutions.

Adoption The development of a permanent plan and the finding of a permanent home for a child or adolescent. Included in this definition is subsidized adoption, a program in which a local department of social services makes financial payments on behalf of a particular child placed in an adoptive home, to the child's adoptive family beyond legal completion of the adoption.

V. Substitute Care Services

An alternative living situation, other than in the home of the natural parent(s), adoptive parents or guardians, into which a child can be or is placed, when remaining at home is not in the best interests of the child.

Emergency and Shelter Care

Emergency care is care that is provided when a child is placed outside the home, for a short period of time, in response to a crisis situation requiring his or her immediate removal from the child's home. Such placement may be in a foster home or shelter care facility.

Shelter care is care that is provided in a multi-bed facility for a short period of time, with the expectation that evaluation services will be provided during, and in conjunction with, the child's placement in that facility, in order to facilitate planning for the child. Such placement can be either on an emergency or on a planned basis.

Emergency foster homes are approved and provided through the local departments of social services. JSA also places children in foster homes identified to provide emergency foster care. Private agencies also provide placements for children through contractual arrangements with state agencies.

Family Foster Care Continuous 24-hour care, in a family setting, for a child who is placed in the custody of a local department or JSA; or a child who is abused, neglected, abandoned, or dependent, and for whom the court determines that remaining in the home is contrary to the child's welfare.

Specialized Foster Care or Individual Family Placement is that type of care that provides more intensive supervision and care than is provided in standard foster care, due to the special needs of the children. Special needs are viewed as emotional, behavioral, physical or mental disabilities that require additional attention.

This type of care can be provided in a foster family home or in a group home or facility. Different models exist and new models are being developed under pilot projects with SSA.

Regular Foster Care is custodial 24-hour care, in a family home, into which a child can be placed. Efforts must be made to reunify the family or to establish another permanency plan for a placed child.

These types of settings are utilized by local departments and JSA, through its foster homes or through arrangements with private agencies.

Residential Services Include a variety of living arrangements provided to children and/or adolescents in which the individual's activities are to some degree managed by other people. These living arrangements are provided in a setting that does not include one's own family home or foster home.

Alternative Living Unit (ALU) An ALU is a residential model for one to three developmentally disabled individuals. Since this model is highly flexible in terms of staff supervision, a growing number of severely to profoundly disabled individuals are being served successfully in this setting through grants provided by the MRDDA to non-profit community providers.

Group Homes A group home is a community-based single family home in which a small number of children and/or adolescents live in a family-like atmosphere with staff serving as role models. The MHA has shared service agreements with several group homes which provide for psychological services to residents who are mentally ill. In addition, the MHA will be providing funds in Fiscal Year 1986 for private therapeutic group homes for emotionally disturbed youth.

MRDDA provides funds for group homes for four to eight individuals. Residents participate in day programs away from the home and use available community services for the majority of their needed support services.

JSA has a state-operated group home for girls as well as one for boys. In addition JSA and DHR/SSA purchase group home services from private vendors.

Small Residential Center The small residential centers funded by the ACA, JSA, and MRDDA are more structured and restrictive than either the ALU or group home.

There are two short-term (45-60 day) facilities for chemically dependent adolescents that have the capacity to serve four hundred (400) adolescents per year.

For mentally retarded children and adolescents a small residential center is often their first step in moving from an institution into the community. These facilities house an average of fifty individuals with moderate to profound levels of retardation.

The JSA has one small residential center which it staffs for thirty (30) males. A school is also located on the grounds of the center.

Non-Public Special Education Facility This is an approved non-public educational facility which provides 24-hour special education programming and personal care to handicapped children.

Residential Treatment Center Residential Treatment Centers are self-contained psychiatric facilities for intermediate to long-term treatment of children and adolescents with severe and chronic mental disorders.

Within Maryland, residential treatment is provided at three state-operated Regional Institutes for Children and Adolescents. Additionally, residential treatment center services may be provided through purchase-of-care or contractual agreements in four private, non-profit facilities (Edgemeade, Villa Maria, Woodbourne, and Good Shepherd).

Special Education may be provided as a service in a residential treatment center.

For children and adolescents with mental retardation, there are five State Residential Centers (SRC) which provide full-time residential care. Before any person is admitted to an SRC, he/she receives a comprehensive evaluation to ensure that the SRC is the least restrictive environment available to meet the individual's specific needs.

Psychiatric Hospital Psychiatric hospitals are highly restrictive intensive inpatient programs for the treatment of severe mental disorders which require hospital-based care to achieve stabilization and/or problem remediation. By Maryland law, adolescents (under 18 years of age) must be located separately from adults in State psychiatric hospitals. Consequently, adolescent services are provided separately at four adolescent units located at Crownsville, Finan Center, Carter Center and Springfield. There are several private psychiatric hospitals which also have adolescent inpatient units (Psychiatric Institute, Brook Lane, Sheppard-Pratt, Chestnut Lodge, and Taylor Manor).

Services include: (a) psychological and medical diagnostic procedures; (b) observation treatment modalities including medication psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation, and milieu treatment; (c) medical care and treatment as needed; (d) supportive services; (e) room and board. Both voluntary and involuntary clients may be served in this setting.

Detention and Commitment Institutions The JSA staffs detention institutions for delinquent juveniles who need a secure short-term placement pending adjudicatory and/or dispositional hearings. Commitment institutions, on the other hand, are for adjudicated delinquent youth whom the Juvenile Court has commited as in need of care and treatment.

ADOLESCENT RESIDENTIAL CHEMICAL DEPENDENCE TREATMENT

DHMH ACA/DAA

SERVICES	Short term residential treatment (45-60 days)
ELIGIBILITY	Chemically dependent adolescents under 18; Maryland residents
WHO PROVIDES	White Oak Center (Cambridge); Jackson Center (Cumberland)
NUMBER SERVED	FY 86, 160 annually (est.)
POTENTIAL POPULATION	An additional 300 adolescents
FUNDING	FY 86 $520,000 (est.); potential, private insurance ($300,000)
AVAILABILITY	Statewide access

GROUP HOME CARE FOR CHEMICALLY DEPENDENT ADOLESCENTS

DHMH ACA/DAA

SERVICES	Group home
ELIGIBILITY	Chemically dependent adolescents under 18 who have completed residential treatment
WHO PROVIDES	(Under development)
NUMBER SERVED	Estimated at 96 per year
POTENTIAL POPULATION	150-200 annually
FUNDING	FY 86, $500,000 (est.)
AVAILABILITY	Metropolitan Baltimore

OUTPATIENT THERAPY FOR CHEMICALLY DEPENDENT ADOLESCENTS

DHMH ACA/DAA

SERVICES	Counseling, outpatient psychiatric therapy
ELIGIBILITY	Chemically dependent adolescents under 18 and their parents
WHO PROVIDES	Local health departments
NUMBER SERVED	FY 86, 2000 adolescents (est.)
POTENTIAL POPULATION	4000 adolescents
FUNDING	FY 86, $750,000 (est.)
AVAILABILITY	Statewide

ACADEMIC/VOCATIONAL PROGRAMS — DHMH JSA

SERVICES	Day education; vocational education; individual counseling; and social programs
ELIGIBILITY	Ages 16-18; must be placed under the supervision of JSA by the Juvenile Court.
WHO PROVIDES	Private vendors reimbursed through JSA Purchase-of-Services funds.
NUMBER SERVED	FY 86, 500 (est.)
POTENTIAL POPULATION	750
FUNDING	FY 86, $428,866. There is a need for more services, but no increase in funds is anticipated.
AVAILABILITY	Statewide

CLINICAL SERVICES — DHMH JSA

SERVICES	Diagnosis, assessment and evaluation
ELIGIBILITY	Ages 17 and under; youth must be alleged to have committed a delinquent act or to be a Child in Need of Supervision.
WHO PROVIDES	JSA staff and individuals on private contracts; services provided in JSA institutions and in the community.
NUMBER SERVED	FY 86, 8,000 (est.)
FUNDING	FY-86, $322,422; need for $400,000 but no increase is anticipated.
AVAILABILITY	Statewide

COMMUNITY ARBITRATION — DHMH JSA

SERVICES	Information and referral; individual and family counseling
ELIGIBILITY	Youth aged 10-17 who commit a misdemeanor.
WHO PROVIDES	JSA staff
NUMBER SERVED	FY 86, 4,200 (est.)
POTENTIAL POPULATION	8,000
FUNDING	FY 86, $580,000; need 100 percent more funds. No increase is anticipated.
AVAILABILITY	Baltimore City, Prince Georges County, Anne Arundel County, and Baltimore County

COUNSELING — DHMH JSA

SERVICES	Family and individual counseling; outpatient psychiatric therapy
ELIGIBILITY	Ages 17 and under; must be placed under the supervision of JSA by the Juvenile Court.
WHO PROVIDES	Private vendors reimbursed through JSA's Purchase-of-Services program.
NUMBER SERVED	FY 86, 2,336 (est.)
POTENTIAL POPULATION	4,000
FUNDING	FY 86, $1,100,000; need a 25 percent increase. No additional funding is anticipated.
AVAILABILITY	Statewide

DETENTION ONLY INSTITUTIONS — DHMH JSA

SERVICES	Secure residential care, pending appearance in Juvenile Court.
ELIGIBILITY	Ages 17 and under; must be alleged to be a delinquent and be considered a danger to self or the community.
WHO PROVIDES	JSA staffed and operated
NUMBER SERVED	Average daily population FY 86, 156 (est.)
POTENTIAL POPULATION	156
FUNDING	FY 86, $9,200,000; no additional funds anticipated.
AVAILABILITY	Montgomery, Kent, Prince George's and Anne Arundel counties.

DIVERSION — DHMH JSA

SERVICES	Family, individual and group counseling; recreation/social programs; and tutoring
ELIGIBILITY	Ages 10-17; must be referred by a JSA intake officer who has received a complaint alleging Delinquent or Child in Need of Supervision behavior.
WHO PROVIDES	Private contractors
NUMBER SERVED	FY 86, 1,941 (est.)
POTENTIAL POPULATION	1,941
FUNDING	FY 1986, $899,000; no change anticipated
AVAILABILITY	Baltimore City and Prince George's County

FOSTER GRANDPARENTS — DHMH JSA

SERVICES	Individual and family counseling; tutoring
ELIGIBILITY	All youths under the supervision of JSA
WHO PROVIDES	Part-time volunteers, aged 60 and older, who are paid a small stipend
NUMBER SERVED	FY 86, 500 (est.)
POTENTIAL POPULATION	500
FUNDING	FY 86, $181,480; no change anticipated
AVAILABILITY	Baltimore City, Cecil, St. Mary's, Baltimore and Dorchester counties.

GOOD SHEPHERD DAY SCHOOL — DHMH JSA

SERVICES	Family and individual counseling; day education
ELIGIBILITY	Female juveniles who are ninth graders or above; must be alleged to be a Delinquent or Child In Need of Supervision
WHO PROVIDES	Good Shepherd has a contract with JSA.
NUMBER SERVED	FY 86, 42 (est.)
POTENTIAL POPULATION	42
FUNDING	FY 86, $78,553; no increase is anticipated
AVAILABILITY	Serves Baltimore City and Baltimore County

GROUP HOMES — DHMH JSA

SERVICES	Individual group and family counseling; recreation/social programs; out-of-home placement in the community
ELIGIBILITY	Ages 17 and under; must be committed to JSA for placement by the Juvenile Court.
WHO PROVIDES	JSA staffs and operates two group homes in Baltimore City. JSA contracts with private vendors for other group home placements.
NUMBER SERVED	FY 86, 159 average daily population (est.)
POTENTIAL POPULATION	Approximately 200
FUNDING	FY 86, $2,603,243; need 25 percent increase. No increase is anticipated.
AVAILABILITY	Baltimore City, Allegany, Frederick, Montgomery, Prince Georges, Kent, Anne Arundel, Baltimore, St. Mary's and Carroll counties.

CHARLES H. HICKEY SCHOOL — DHMH JSA

SERVICES	Detention institution; commitment institution
ELIGIBILITY	Males 7-17 for detention and males 15½-18 for commitment; youth must be an alleged Delinquent.
WHO PROVIDES	Staffed and operated by JSA.
NUMBER SERVED	FY 86 detention, average daily population of 40 (est.); commitment, average daily population of 390
POTENTIAL POPULATION	430
FUNDING	FY 86, $11,162,462; no increase anticipated
AVAILABILITY	Statewide

IN-HOME ALTERNATIVES TO DETENTION AND COMMITMENT PROGRAMS — DHMH JSA

SERVICES	Individual and family counseling
ELIGIBILITY	Ages 10-17; must be detained or commited by the Juvenile Court, then selected for one of these in-home programs
WHO PROVIDES	Both JSA and private contractors provide these programs.
NUMBER SERVED	FY 86, community detention, 1,021 (est.); in-home commitment alternative, 480
POTENTIAL POPULATION	1,500
FUNDING	Fy 86, $1,183,000; need for $1.5 million, but no increase is expected.
AVAILABILITY	Baltimore City, Prince Georges, Anne Arundel, Harford, and Baltimore counties.

INTAKE — DHMH JSA

SERVICES	Family and individual counseling; information and referral
ELIGIBILITY	Ages 17 and under; must be referred for alleged Delinquent or Child in Need of Supervision behavior.
WHO PROVIDES	JSA staff
NUMBER SERVED	Fy 86, 36,000 (est.)
POTENTIAL POPULATION	36,000
FUNDING	FY 86, $3,484,233; no change anticipated
AVAILABILITY	Statewide

MONTROSE SCHOOL — DHMH JSA

SERVICES	Detention institution; commitment institution
ELIGIBILITY	Females 7-17 and males 7-15 years of age. Only delinquents may be sent to Montrose.
WHO PROVIDES	Staffed and operated by JSA.
NUMBER SERVED	FY 86, detention, average daily population 30 (est.); commitment, average daily population 240
POTENTIAL POPULATION	270
FUNDING	FY 86, $7,605,614; no increase anticipated
AVAILABILITY	Statewide

MURPHY YOUTH SERVICE CENTER — DHMH JSA

SERVICES	Individual counseling; day education; and vocational education
ELIGIBILITY	Must be 16 or older, adjudicated a Child in Need of Supervision or Delinquent and placed under the supervision of JSA.
WHO PROVIDES	JSA operated and staffed
NUMBER SERVED	FY 86, 100 estimated average daily enrollment. The capacity is 100.
POTENTIAL POPULATION	The Murphy Youth Service Center is meeting the need for this service in this geographic location. A similar program in East Baltimore or about ten other locations in the state would each have a potential population of 100 youth.
FUNDING	FY 1986, $697,900; no increase is planned. There is a great need for this type of program, but academic and vocational training is not viewed by JSA as its mandate.
AVAILABILITY	Baltimore City (one location).

PROTECTIVE SUPERVISION, PROBATION AND AFTERCARE — DHMH JSA

SERVICES	Individual, family and group counseling; information and referral
ELIGIBILITY	Must be adjudicated a Delinquent, or a Child in Need of Supervision and placed under the supervision of JSA.
WHO PROVIDES	JSA staff
NUMBER SERVED	FY 86, 7022 (est.)
POTENTIAL POPULATION	7,022
FUNDING	FY 86, $8,000,000; no change anticipated
AVAILABILITY	Statewide

SHELTER CARE — DHMH JSA

SERVICES	Family shelter care; structured group shelter care
ELIGIBILITY	Ages 17 and under; must be alleged to be a Delinquent or Child in Need of Supervision and must be a danger to self or to the community.
WHO PROVIDES	Private vendors. JSA pays a daily rate to families for family care, and a higher rate to a vendor who provides structured shelter care.
NUMBER SERVED	FY 86, average daily population of 37 youth in family care (est.); structured shelter, average daily population of 73
POTENTIAL POPULATION	Need about 25 percent more shelter care family homes.
FUNDING	FY 86, $1,411,147; no increase expected.
AVAILABILITY	Statewide

SMALL RESIDENTIAL CENTERS, RESIDENTIAL TREATMENT CENTERS, PSYCHIATRIC HOSPITALS — DHMH JSA

SERVICES	24-hour supervision; psychiatric, psychological and social services; day education; recreation/social programs
ELIGIBILITY	Ages 17 and under; must be committed to JSA for placement by the Juvenile Court.
WHO PROVIDES	JSA staffs and operates one center in Baltimore City (Maryland Youth Residence Center), and purchases care from private vendors in Maryland and other states; a major vendor is Good Shepherd Center.
NUMBER SERVED	Average daily population FY 86, 303 (est.)
POTENTIAL POPULATION	There is a need for a 25 percent increase in placements.
FUNDING	FY 86, $6,292,000; need 25 percent increase. No additional funds are anticipated.
AVAILABILITY	Baltimore City, Baltimore County, Prince George's County, Montgomery County, Howard County and Washington County, and several out-of-state vendors.

VOLUNTEER PROGRAM — DHMH JSA

SERVICES	Individual counseling; recreation/social programs; and tutoring
ELIGIBILITY	Ages 17 and under; must be alleged to be a Delinquent or Child in Need of Supervision.
WHO PROVIDES	JSA staff coordinate the efforts of volunteers who are student interns and private citizens.
NUMBER SERVED	FY 86, 1,880 (est.)
POTENTIAL POPULATION	2,000
FUNDING	FY 86, $102,892; no increase anticipated
AVAILABILITY	Statewide

YOUTH CENTERS — DHMH JSA

SERVICES	Commitment institutions
ELIGIBILITY	Males aged 15½-18 who are committed to the care and custody of JSA due to being found to be a Delinquent.
WHO PROVIDES	Operated and staffed by JSA.
NUMBER SERVED	FY 86, 234 (est.)
POTENTIAL POPULATION	234
FUNDING	FY 86, $3,478,448; potential funding, $4,700,000 as two new youth centers will be added within one year.
AVAILABILITY	Garrett and Allegany counties. Youth centers will soon be complete in Carroll and Charles counties.

YOUTH SERVICES BUREAUS — DHMH JSA

SERVICES	Community education; information and referral; family and individual counseling; social programs; tutoring; and parent education
ELIGIBILITY	All juveniles aged 7-17, not under the supervision of JSA.
WHO PROVIDES	Each youth services bureau is a separate private contractor.
NUMBER SERVED	FY 86, 30,000 (est.)
POTENTIAL POPULATION	40,000
FUNDING	FY 86, $1,879,689 general funds; a 25 percent increase is needed, no increase is anticipated.
AVAILABILITY	There are 20 youth services bureaus statewide. They are in Annapolis, Bethesda, Bowie, Carroll County, Dorchester County, Dundalk, East Baltimore, Baltimore County, Gaithersburg, Glenarden, Greenbelt, Harundale, Laurel, Catonsville, North Central and Northwest Baltimore City, Parkville, Rockville, and Charlotte Hall.

COMMUNITY MENTAL HEALTH, INFANTS AND YOUNG CHILDREN — DHMH MHA

SERVICES	Community education; primary health care (well-baby clinics); information and referral; programs to identify and prevent developmental problems in at-risk children; parent education or other parent support programs; diagnosis, assessment, evaluation, and medical services coordination; family and individual counseling; outpatient psychiatric therapy; and day education/treatment programs
ELIGIBILITY	Infants and young children and their families
WHO PROVIDES	Community mental health clinic; there are no direct purchase-of-service agreements in the special programs.
NUMBER SERVED	FY 86, 221 (est.)
FUNDING	FY 86, $425,800
AVAILABILITY	Bowie Therapeutic Nursery, Southern Maryland Region; Children's Guild, Central Maryland Region; University of Maryland Early Infancy Psychiatric Training Program, Central Maryland Region (training only); and Regional Center for Infants and Children, Southern Maryland Region

COMMUNITY MENTAL HEALTH CLINICS — DHMH MHA

SERVICES Community education; information and referral; diagnosis, assessment, evaluation and medical services coordination; family and individual counseling; and outpatient psychiatric therapy. Some community mental health clinics also provide primary health care; hotlines and telephone messages; programs to identify and prevent developmental problems in at-risk children; and parent education or other parent support programs.

ELIGIBILITY Children and adolescents and their families who are citizens of Maryland, regardless of their ability to pay

WHO PROVIDES Grants to mental health clinics; some receive supplemental funding from other sources such as local funds. No direct purchase-of-service agreements, but community mental health clinics may use MHA grant funds to purchase specific services.

NUMBER SERVED FY 85, 4715 children and adolescents under 18

POTENTIAL POPULATION Approximately 3 percent of children and adolescents require professional care from mental health specialists.

FUNDING FY 86, $3.2 million (est.). It is anticipated that if the under 21 years of age medical option is accepted in Maryland, funds would be utilized toward expansion of mental health services for children and adolescents.

AVAILABILITY Statewide

RESIDENTIAL TREATMENT CENTERS — DHMH MHA

SERVICES Diagnosis, assessment, evaluation and medical services coordination; family and individual counseling; outpatient psychiatric therapy; day education/treatment programs; recreation/social programs; personal care; transportation; vocational education and transitioning programs; tutoring; group therapy; and milieu therapy

ELIGIBILITY Long-term and severe mental disorder; treatment needs that cannot be met through available community-based programs; between 12 and 17 years old (age limit may be waived in appropriate cases). A RICA may not admit a child or adolescent who has a primary diagnosis of alcoholism, drug addiction, or severe brain damage; or cognitive deficits which severely limit the individual's ability to use the treatment modalities provided.

WHO PROVIDES Residential treatment is provided at three state-operated Regional Institutes for Children and Adolescents (RICA); MHA also provides funding through contract for Villa Maria which is a licensed residential treatment center for children.

NUMBER SERVED FY 86, 260 beds (est.)

FUNDING FY 86, $7,773,247 (est.) for RICA's; some local education funding (LEA) is not included; Villa Maria, $2,600,000

AVAILABILITY RICA I (Baltimore) - Baltimore, Anne Arundel, Carroll, Harford, and Howard counties and Baltimore City; RICA II (Rockville) - Montgomery, Prince Georges's and Frederick counties; RICA III (Cheltenham) - St. Mary's, Calvert, Charles and part of Prince George's counties; Villa Maria, which is located in Baltimore County, serves the entire state. These catchment areas are being renegotiated to enable greater access to RICA's statewide.

DAY TREATMENT — DHMH MHA

SERVICES	Diagnosis, assessment, evaluation and medical services coordination; family and individual counseling; outpatient psychiatric therapy; day education/treatment programs; recreation/social programs; personal care; transportation; vocational education and transitioning programs; tutoring; and group therapy
ELIGIBILITY	Children and adolescents who have severe emotional disturbance
WHO PROVIDES	In conjunction with the local school system
NUMBER SERVED	FY 86, 230 slots (est.)
FUNDING	FY 86, $5,400,000 (est.) (Figures do not include LEA contributions to the educational programs.)
AVAILABILITY	RICA I - Baltimore, Harford, Anne Arundel, Carroll, Howard counties and Baltimore City; RICA II - Montgomery, Prince Georges's and Frederick counties; RICA III - Prince George's, Charles, Calvert and St. Mary's counties; Frederick County Program - Frederick County only.

INPATIENT PSYCHIATRIC — DHMH MHA

SERVICES	Diagnosis, assessment, evaluation and medical services coordination; family and individual counseling; outpatient psychiatric therapy; day education/treatment programs; recreation/social programs; personal care; transportation; vocational education and transitioning programs; tutoring; group therapy; and milieu therapy
ELIGIBILITY	Individuals under the age of 18 years who have mental disorders requiring care and treatment in a psychiatric inpatient program
WHO PROVIDES	MHA provides inpatient psychiatric treatment through four adolescent units located at the following state hospital centers: Crownsville, Finan, Carter and Springfield.
NUMBER SERVED	379 admissions
FUNDING	Included in total facility budget
AVAILABILITY	Statewide access

THERAPEUTIC GROUP HOMES — DHMH MHA

SERVICES	Community-based residential care, treatment, and case management for severely disturbed children and youth
ELIGIBILITY	Individuals under 18 years of age who, because of a mental disorder, require residential services not available in the home
WHO PROVIDES	Private providers through MHA funding (In FY 87, JSA and SSA will contribute through a cooperative funding plan.)
NUMBER SERVED	FY 86, 20 beds
POTENTIAL POPULATION	209 youth
FUNDING	FY 86, $410,000; FY 87, $835,000
AVAILABILITY	Southern, Eastern, and Central Maryland

CRIPPLED CHILDREN'S SERVICES — DHMH MRDDA

SERVICES	Community education, information and referral, programs to identify and prevent developmental problems in at-risk children, parent education and parent support, evaulation, assessment and diagnostic service coordination, family and individual counseling, day care, specialized equipment, and specialized medical services
ELIGIBILITY	Individuals under 21 years of age, who are residents of Maryland, with handicapping conditions; eligibility is based on health need rather than financial circumstances alone. Total family situation, other illness, medical expenses in the family, cost of health care, and duration of condition or handicap is considered.
WHO PROVIDES	Service delivery and coordination responsibilities are shared with the 24 local health departments, community health agencies, and approved private providers. Reimbursement is provided to attending clinicians for in-hospital care, as well as reimbursement for therapies and specialized equipment/devices. Grant funds are awarded for various services/programs.
NUMBER SERVED	FY 86, 14,000 (est.)
FUNDING	FY 86, general funds, $3,558,300; federal funds, $1,478,491. Yearly increments depend on inflation in the general economy.
AVAILABILITY	Statewide

FAMILY SUPPORT SERVICES — DHMH MRDDA

SERVICES	Family and individual counseling, recreation/social programs, day care, specialized equipment and housing adaptations, transportation, specialized medical services, information and referral, parent education and parent support, evaluation, assessment and diagnostic service coordination
ELIGIBILITY	Children/adolescents with developmental disabilities younger than age 22 for whom support services are needed to assist in the prevention of out-of-home placements
WHO PROVIDES	Individual grants to The Kennedy Institute, Frederick County Association for Retarded Citizens, Calvert Association for Retarded Citizens, Jewish Social Service Agency, and the Epilepsy Association of the Eastern Shore
NUMBER SERVED	FY 85, 150
POTENTIAL POPULATION	8,891 to 15,393 (between .67 percent and 1.16 percent of general population younger than 22)
FUNDING	FY 86, $220,000 ($110,000 from MRDDA-general funds and $110,000 reimbursable funds from the Developmental Disabilities Council - federal funds) yearly increments depend on inflation in the general economy
AVAILABILITY	Baltimore City, Baltimore, Frederick, Calvert, Montgomery counties, and nine Eastern Shore counties

INDIVIDUAL FAMILY PLACEMENT — DHMH MRDDA

SERVICES	Specialized family care
ELIGIBILITY	An individual with mental retardation in need of assistance and requiring removal from current living situation due to any of a variety of reasons including inappropriate behaviors, or being in need of protection
WHO PROVIDES	Special payments to individuals who are certified by the MRDDA to provide specialized family care
NUMBER SERVED	FY 85, 35
POTENTIAL POPULATION	MRDDA is looking at the whole concept of community-based individual family placements and has drafted regulations for such. It is the Administration's intent to gradually shift the operation of the individual family placement programs which are currently operated by state residential centers to interested community providers.
FUNDING	FY 86, $167,000
AVAILABILITY	Southern, Central and Western Maryland regions

COMMUNITY RESIDENTIAL SERVICES FOR MENTALLY RETARDED PERSONS — DHMH MRDDA

SERVICES	Alternative living units, group homes, small residential centers, parent education and parent support, evaluation, assessment and diagnostic service coordination, recreation/social programs, transportation
ELIGIBILITY	Children/adolescents younger than age 22 with mental retardation, who are most at risk of institutionalization, without the provision of alternative out-of-home residential placements; Medicaid Waiver clients — individuals who were living at state residential centers (SRC), are recipients of or eligible for Medical Assistance, are certified as being in need of ICF/MR level of care, and are determined appropriate for community services through a joint process that includes the SRC client, the SRC interdisciplinary team, and the community provider agency.
WHO PROVIDES	Individual grants to 16 non-profit community agencies in FY 85
NUMBER SERVED	FY 85, 150
POTENTIAL POPULATION	The total number of community residential beds for individuals of all ages has increased from less than 400 in 1978 to more than 2,000 anticipated in FY 86; approximately 2,600 individuals remain on waiting lists for MRDDA services.
FUNDING	General funds FY 85, $1,543,922. A claim has been submitted for partial reimbursement from the federal Medicaid Waiver program, but a determination has not yet been made. The possibility of further expansion of Medicaid Waiver may result in maximizing federal financial participation.
AVAILABILITY	Statewide

PURCHASE OF CARE — DHMH MRDDA

SERVICES	Residential treatment (does not include MRDDA's state residential centers)
ELIGIBILITY	Individuals who are severely educationally handicapped and whose needs cannot be met through existing programs
WHO PROVIDES	Non-profit community residential providers within Maryland; various Level 6 residential treatment centers outside Maryland
NUMBER SERVED	FY 85, 23
FUNDING	FY 85, $404,800 (est.); yearly increments depend on inflation in the general economy
AVAILABILITY	Statewide and throughout the country

COMMUNITY RESIDENTIAL SERVICES FOR NON-RETARDED DEVELOPMENTALLY DISABLED — DHMH MRDDA

SERVICES	Alternative living units, group homes, parent education and parent support, evaluation, assessment and diagnostic service coordination, recreation/social programs, transportation
ELIGIBILITY	An individual whose disability is attributable to cerebral palsy, epilepsy, autism, dyslexia, or any other neurological malfunction or disorder; can be expected to continue indefinitely; and is a substantial handicap to the ability of the individual to function normally in society
WHO PROVIDES	Individual grants to non-profit community agencies
NUMBER SERVED	FY 85, approximately five children
POTENTIAL POPULATION	Applying nationally accepted prevalence statistics, it is estimated 8,000 to 15,000 children in Maryland are developmentally disabled
FUNDING	Average annual cost of residential services for persons who are non-retarded developmentally disabled is $16,000. There is an anticipated increase in services for victims of traumatic head injuries. Annual cost of non-medical services is anticipated to be $35,000; yearly increments depend on inflation in the general economy
AVAILABILITY	Statewide

SUMMER DAY PROGRAM — DHMH MRDDA

SERVICES	Recreation/social programs
ELIGIBILITY	Children/adolescents with developmental disabilities
WHO PROVIDES	Individual grants to government entities (health departments, departments of parks and recreation) some of whom subcontract with individual providers. There are a total of 28 providers of MRDDA-funded summer day programs.
NUMBER SERVED	FY 86, 1,953
POTENTIAL POPULATION	.67 percent to 1.16 percent of general population younger than 22 years
FUNDING	FY 86 $247,692, general funds; yearly increments depend on inflation in the general economy
AVAILABILITY	Statewide

STATE RESIDENTIAL CENTERS — DHMH MRDDA

SERVICES	Evaluation, assessment and diagnostic service coordination; day education; recreation/social programs; specialized medical services; volunteers; full-time residential care
ELIGIBILITY	Findings of a comprehensive evaluation determine that the individual is mentally retarded; and, for protection or adequate habilitation, needs habilitation services; and there is no available less restrictive form of treatment that is consistent with the welfare and safety of the individual
WHO PROVIDES	Five state-owned/operated state residential centers serve children: Rosewood, Great Oaks, Holly Center, Potomac Center, and Highland Health Facility
NUMBER SERVED	FY 85, 269
POTENTIAL POPULATION	It is anticipated that there will be a 40 percent decrease in the total number of SRC licensed beds between 1983-1993, with a total of 1,664 beds available in 1993.
FUNDING	$9,308,207 (based on an average cost of $34,603 for serving an SRC client, February 1984 to January 1985). FY 86 total allocation to all SRCs is $78,740,000; children/adolescents comprise approximately 14 percent of the SRC population.
AVAILABILITY	Statewide

CASE MANAGEMENT/ SERVICES COORDINATION — DHMH MRDDA

SERVICES	Community education, information and referral, parent education and parent support programs, evaluation, assessment and diagnostic service coordination, family and individual counseling
ELIGIBILITY	An individual with mental retardation; or an individual who is non-retarded developmentally disabled, is currently receiving services through the MRDDA, and has been specifically identified to receive services coordination (Every client in the Medicaid Waiver program receives services coordination.)
WHO PROVIDES	Calvert, Charles, Prince George's, St. Mary's, Worcester, Baltimore City, Baltimore County health departments; Frederick County Association for Retarded Citizens (for Central and Western counties); Montgomery Family Resources; Holly Center Foundation (for Eastern Shore counties).
NUMBER SERVED	FY 85, less than 200 children/adolescents
POTENTIAL POPULATION	Total number to be served in FY 86 (adults and children/adolescents) 2,140
FUNDING	FY 85 average annual per capita, $958 general funds; yearly increments depend on inflation in the general economy; possible reimbursement of federal funds through the Medicaid Waiver program
AVAILABILITY	Statewide

ADOLESCENT PREGNANCY AND PREVENTION — DHMH PMA

SERVICES	Provides an Adolescent Case Coordinator — community based multi-service person to assist the Adolescent Pregnancy Prevention program in dealing with problems of parenthood
ELIGIBILITY	Pregnant, parenting, or adolescents at risk of pregnancy who present themselves to the participating local health department
WHO PROVIDES	A Case Coordinator, who may be a social worker, a community health nurse, or a person qualified to perform coordination
NUMBER SERVED	1,333, aged 17 and under
POTENTIAL POPULATION	Approximately 16,000 sexually active teenagers aged 14 to 17
FUNDING	FY 86, $213,000
AVAILABILITY	Baltimore City, Caroline, Cecil, Charles, Dorchester, Garrett, Kent, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester counties.

CHILD HEALTH CLINICS OF LOCAL HEALTH DEPARTMENTS — DHMH PMA

SERVICES	Preventive health maintenance; preventive health screenings; referral; follow-up
ELIGIBILITY	Age range varies. Some clinics serve children from birth to age five, others serve children to age 21. Of the 24 jurisdictions, 22 provide services (Talbot and Dorchester do not). Approximately 80 percent are "gray area" and 20 percent Medical Assistance.
WHO PROVIDES	Interdisciplinary staff of local health departments
NUMBER SERVED	Approximately 61,000 in 1980
POTENTIAL POPULATION	All children in Maryland from birth to age 21, approximately 1.4 million.
FUNDING	Title V, state and local funds (through case formula); and the EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program through Medical Assistance
AVAILABILITY	Statewide

HEREDITARY DISORDERS — DHMH PMA

SERVICES	Full range of genetic services including education, counseling, diagnosis, and treatment; also newborn screening and follow-up of abnormals and identified cases. A birth defects reporting and information system provides information as requested for families of children with birth defects. AFP (alpha-fetoprotein) screening program provides counseling/follow-up for women with abnormal results. Genetics education programs are available. Sickle cell testing/counseling, education available.
ELIGIBILITY	Maryland residents
WHO PROVIDES	Clinic centers staffed by board certified M.D./Ph.D. geneticists, and board certified genetic counselors. Otherwise, appropriately trained and certified providers, such as nutritionists, for PKU follow-up.
NUMBER SERVED	FY 86, 72,000 (est.)
FUNDING	$639,000
AVAILABILITY	Statewide

HIGH RISK INFANT FOLLOW-UP

DHMH **PMA**

SERVICES	Follow-up care of infants discharged from regional intensive care nurseries. Services include: parent and family support services through ongoing relationship with the community health nurse, including regular contacts, counseling, and referral; assessment by the community health nurse of infant's growth and developmental progress at time of discharge, at 4-6 months and 12 months; and contact and consultation with parents, as needed.
ELIGIBILITY	Admission to regional intensive care nursery; infants with identified biomedical and environmental risk factors
WHO PROVIDES	Trained community health nurses in participating county health departments have responsibility to follow their own caseloads.
NUMBER SERVED	2000
POTENTIAL POPULATION	All infants meeting the criteria for high risk follow-up; approximately 2000 infants discharged from seven Maryland regional intensive care nurseries
FUNDING	FY 86, $248,600
AVAILABILITY	Baltimore City, Baltimore County, and Washington County

IMMUNIZATION

DHMH-**PMA**

SERVICES	Vaccination of children and adolescents
ELIGIBILITY	None
WHO PROVIDES	The Immunization program purchases measles, mumps, rubella (MMR), and oral polio vaccines (DPV) and provides them to local health departments at no cost. The program also contributes funds to local health departments for the purchase of DTP vaccine. The vaccines are administered in local health department clinics.
NUMBER SERVED	FY 86, 85,986 (est.)
POTENTIAL POPULATION	Approximately 15 percent of the birth to age five population on a regular basis; perhaps 30 percent on a sporadic basis
FUNDING	During FY 84, the Immunization program spent approximately $200,000 in direct assistance federal funds on MMR and OPV vaccines. In addition, it provided $9,700 to local health departments to supplement their purchase cost for DTP vaccine.
AVAILABILITY	Statewide

LEAD POISONING PREVENTION

DHMH **PMA**

SERVICES	Screening for increased lead absorption; medical counseling about effects of increased lead absorption; nutritional counseling; and environmental counseling
ELIGIBILITY	Children attending child health clinics and children receiving Medical Assistance
WHO PROVIDES	All EPSDT providers, all local health departments with child health clinics
NUMBER SERVED	In 1983 approximately 45,000 children were screened in Maryland
POTENTIAL POPULATION	All children under five years of age
FUNDING	Title V funds, matching county case formula funds, Medical Assistance for EPSDT children
AVAILABILITY	Statewide

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

DHMH **PMA**

SERVICES	Comprehensive health care (including preventive, acute and long-term or chronic); outreach; and case management
ELIGIBILITY	Children eligible for Medical Assistance, from birth through 20 years of age
WHO PROVIDES	The state Medicaid program within DHMH purchases health care for eligible clients from a variety of certified EPSDT providers statewide: 22 local health departments; Children and Youth clinics in Baltimore City; HMO's; CHC's; and approximately 250 physicians in the private sector.
NUMBER SERVED	56,946 in FY '84
POTENTIAL POPULATION	Approximately 160,000 eligible children at any given time
FUNDING	In FY 84 the Medicaid Program paid $1.9 million for preventive screenings as follows: $406,253 to local health departments for 13,142 screenings; $113,901 to HMO's for 3,488 screenings; $539,040 to C&Y clinics for 17,968 screenings; $840,806 to private physicians for 22,348 screenings. In addition, beginning in FY 86 Medicaid will provide $1 million to local health departments for outreach and case management of EPSDT clients. Medicaid is planning to increase its reimbursement fee for EPSDT screening (preventive) visits.
AVAILABILITY	Statewide

MARYLAND REGIONAL NEONATAL PROGRAM

DHMH **PMA**

SERVICES	Nine designated regional nurseries provide comprehensive diagnostic and treatment services for high-risk newborns. The program is based at MIEMSS and is directed by Johns Hopkins and the University of Maryland. It provides an emergency neonatal transport service as well as outreach education. The focus of both transport and outreach is the acute care of distressed infants.
ELIGIBILITY	Any newborn requiring medical care which is beyond the capabilities of the local hospital.
WHO PROVIDES	Regional neonatal intensive care units (NICU's): Johns Hopkins, University of Maryland, Francis Scott Key, Sinai, Mercy, St. Agnes, Greater Baltimore Medical Center, D. C. Children's, and University of West Virginia. Transportantion and Outreach: MRNP/MIEMSS, Johns Hopkins, and University of Maryland
NUMBER SERVED	650 transports a year; NICU admissions to Maryland hospitals, estimated 2000 a year
FUNDING	State funding for transport, $279,022 (FY 86); IPO grant, $86,147 (FY 86)
AVAILABILITY	All NICU's in Maryland are in the Baltimore area. D.C. Children's hospital serves residents in the D.C. area. The University of West Virginia serves Western Maryland. Transportation is provided from any area of the state or surrounding border areas to the NICU's in Baltimore.

MATERNAL HEALTH PRENATAL CLINICS — DHMH PMA

SERVICES	*Provision of prenatal care; identification of high-risk patients; referral of high-risk patients*
ELIGIBILITY	Services are available for all pregnant indigent patients; patients on Medical Assistance; and patients who desire to have their prenatal care through the local health department and are charged according to the sliding fee schedule.
WHO PROVIDES	Services are provided in participating local health departments with personnel funded through case formula, Title V Block Grant money and personnel provided through the main office (certified nurse midwife physicians). Local health departments hire physicians for maternity clinic coverage.
NUMBER SERVED	FY 84, 8,856
POTENTIAL POPULATION	"Gray area" patients, who are now 54 percent of all registrants, will increase due to a shifting of this population from the private sector to the public sector. Presently, 36 percent of all registrants are under the age of 19.
FUNDING	FY 85 funding, $270,982, through MCH Block Grant and state-funded Project 201.
AVAILABILITY	Statewide, except in St. Mary's County where maternal care is provided through the private sector.

SCHOOL HEALTH PROGRAM — DHMH PMA

SERVICES	Screening for scoliosis, hearing and vision, immunization status; maintenance of a healthy school environment; and health education
ELIGIBILITY	Enrollment in school
WHO PROVIDES	See Section 7-401 Public School Laws of Maryland. Joint mandate of local education agencies and local health departments. In 19 subdivisions, services provided by the local health department; in four subdivisions, services provided by the education agency; in Baltimore County, education provides secondary school health services and the local health department provides elementary school health services.
NUMBER SERVED	Approximately 673,840 (1984) enrollees
POTENTIAL POPULATION	Same
FUNDING	Title V, case formula
AVAILABILITY	Statewide

SPECIAL SUPPLEMENTAL FOOD FOR WOMEN, INFANTS, AND CHILDREN — DHMH WIC

SERVICES	Supplemental nutritious food as well as limited health appraisal and nutrition education
ELIGIBILITY	185 percent of poverty level which currently is $19,703 for a family of four
WHO PROVIDES	Local health departments, community action agencies, private agencies
NUMBER SERVED	FY 85, 48,500
POTENTIAL POPULATION	108,000
FUNDING	FY 86, $20 million
AVAILABILITY	Statewide

DAY CARE — DHR SSA

SERVICES	Purchase of Day Care for income eligible and special needs children
ELIGIBILITY	Priority given to low-income, working parents. Children referred due to abuse or neglect, for whom day care is required as part of a service plan, will receive care without regard to income.
WHO PROVIDES	Purchased from family day care homes and group day care centers
NUMBER SERVED	FY 86, 7445
FUNDING	FY 86, $16,350,000
AVAILABILITY	Statewide

FAMILY SUPPORT CENTERS — DHR SSA

SERVICES	Services designed to enhance parenting skills. Structured "parent education" classes may be a part of this service. Centers will provide: parenting enhancement activities through informal interactions, role modeling, and other parenting support services; health care counseling and other services to avoid unwanted pregnancies; diagnostic and assessment services to identify developmental problems of the young parent and the child; child care as necessary to allow participation in the activities of the centers; peer support activities, including recreational and social activities; educational services as appropriate such as GED and post-high school classes; job preparation and skill development as appropriate to assist parents secure or maintain employment.
ELIGIBILITY	Parents of young children (birth to age three), with emphasis on adolescent parents. Persons who do not meet the definition of parents with young children referred to other programs or services.
WHO PROVIDES	Community agencies under contract to DHR
NUMBER SERVED	FY 86, 500 parents with young children (est.)
POTENTIAL POPULATION	In Maryland, 8,771 births occurred to mothers age 20 or younger in 1983. In Baltimore City, over 3,000 adolescent girls gave birth in 1983. Because demographic information indicates no dramatic change likely in these trends, the potential population for family support centers is estimated conservatively at 8,700 mothers and an equal number of fathers and also of babies, for a total potential population of at least 26,100 persons.
FUNDING	FY 86, $397,000 (general funds, $297,000; the Aaron Straus and Lillie Straus Foundation and the Morris Goldseker Foundation have each contributed $50,000 to the program.)
AVAILABILITY	The program is planned statewide. Initially the centers are in Anne Arundel County, Prince George's County, and Baltimore City.

FOSTER CARE — DHR SSA

SERVICES	Emergency/shelter care, foster family care, specialized family care, group homes, residential treatment
ELIGIBILITY	Any abandoned, abused, neglected or dependent child committed to the local department of social services
WHO PROVIDES	Local departments of social services
NUMBER SERVED	5,000 children (October, 1985)
FUNDING	Board payments - $19,452,000; social services in local departments - $16,800,000
AVAILABILITY	Statewide

H.E.L.P. RESOURCE PROJECT — DHR SSA

SERVICES Community Education and other activities to prevent child abuse and neglect. The H.E.L.P. Resource Project provides a ranges of materials to schools, community agencies and other groups to assist them in child abuse prevention. H.E.L.P. staff provide or promote training of social workers, attorneys, judges, law enforcement agents and health professionals in the area of child abuse and neglect prevention. With federal funds, H.E.L.P. administers child abuse and prevention mini-grants.

ELIGIBILITY The H.E.L.P. Project serves as a resource to any group/organization/agency/professional interested in the area of abuse and neglect prevention. H.E.L.P. mini-grants are available to any non-profit private or public organization.

WHO PROVIDES Mini-grants are awarded to community agencies

NUMBER SERVED The training and information provided through H.E.L.P. reach several thousand individuals each year.

FUNDING FY 86, $155,000 (mini-grants)

AVAILABILITY Baltimore City, Baltimore, Garrett, Howard, Montgomery, Washington and Wicomico counties

INTENSIVE FAMILY SERVICES — DHR SSA

SERVICES Family and individual counseling, teaching parenting skills, child development, crisis intervention, application of family services techniques, on-going case assessment, purchase of concrete services (food, clothing, shelter, day care, transportation, respite care), and purchase of specialized services (diagnostic testing, family therapy, psychiatric treatment, substance abuse or sexual abuse treatment)

ELIGIBILITY Families in which a child is at risk of foster care placement

WHO PROVIDES Local departments of social services - family assessment, counseling, information and referral, transportation, application of family services techniques, crisis intervention, parenting skills, family systems training, child development information; purchased - specialized testing and evaluation, shelter, career training, in-depth counseling and skills training, household needs, transportation, respite care, specialized in-depth treatments

NUMBER SERVED FY 86, 600 families

POTENTIAL POPULATION With present statewide staff allocations the number of families (600) with children (1,000) that can be served will remain fairly constant.

FUNDING FY 86, $1,200,000

AVAILABILITY Baltimore City, Frederick, Washington, Charles, St. Mary's, Calvert, Cecil, Harford, Anne Arundel, Wicomico, Prince George's, Montgomery and Baltimore counties.

PROTECTIVE SERVICES FOR CHILDREN

DHR SSA

SERVICES	Investigation of child abuse, family and individual counseling, as part of continuing protective services
ELIGIBILITY	Protective services investigations are provided for all referrals/reports of child neglect and abuse which come to local departments of social services. Continuing services are provided to all families who require the service.
WHO PROVIDES	Protective services staff, located in local departments of social services, with cooperation in investigations from local law enforcement agencies
NUMBER SERVED	Referrals/investigations - 17,400 (total received for FY 85), continuing cases - 4,100 (average monthly caseload)
POTENTIAL POPULATION	In the past two years, the rate of child abuse reports has increased by approximately 20 percent per year. There is little expectation that the increasing rate of referrals will decrease significantly in the near future.
FUNDING	FY 86, $12,938,000
AVAILABILITY	Statewide

RESPITE CARE

DHR SSA

SERVICES	Respite care
ELIGIBILITY	Developmentally disabled, or disability manifested prior to age 22, or disabling head injury irrespective of age; injuries or disability are likely to continue indefinitely; at least three limitations exist in areas of life activities, such as, self-care, language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency
WHO PROVIDES	Purchased from private agency under contracts
NUMBER SERVED	FY 86, 615 children (from a total caseload of 1229 persons)
POTENTIAL POPULATION	A waiting list of 300 exists beyond present program capabilities
FUNDING	FY 86, $465,000
AVAILABILITY	Statewide access

SERVICES TO FAMILIES WITH CHILDREN

DHR SSA

SERVICES	Emergency/crisis intervention services; placement prevention services; family counseling; individual counseling; information and referral services
ELIGIBILITY	Families with a gross annual income less than 80 percent of the median income
WHO PROVIDES	Local departments of social services
NUMBER SERVED	FY 85, 3000 (average monthly caseload)
POTENTIAL POPULATION	Approximately 10 percent of the AFDC clients in Maryland, based on recent trends
FUNDING	FY 86, $8,300,000
AVAILABILITY	Statewide

SINGLE PARENT SERVICES — DHR SSA

SERVICES	Family and individual counseling as well as referral to appropriate community resources
ELIGIBILITY	Youth under age 18 who are pregnant or at risk of pregnancy, or single parents with children under three years of age
WHO PROVIDES	Local departments of social services
NUMBER SERVED	FY 86, 1600 (est.)
POTENTIAL POPULATION	8771 - The Maryland Center for Health Statistics indicates that in 1983 there were 8771 births to women under age 20. This figure represents a minimum, potential single parent services population when the at-risk populations and single parents with children under three are considered.
FUNDING	FY 86, $1,012,400
AVAILABILITY	Statewide

SUBSIDIZED ADOPTION — DHR SSA

SERVICES	Information and referral; family and individual counseling; specialized equipment and adaptation; assessments (psycho-social, medical, psychiatric)
ELIGIBILITY	Any foster child who cannot be reunited with birth parents or extended birth family. Majority of children served are special needs children.
WHO PROVIDES	Agency - information and referral; family and individual counseling; pre- and post-placement; psycho-social evaluation of child; adoptive home evaluation; (subsidized adoption - subsidy paid to family adopting special needs children, pre- and post-adoption); purchased - specialized equipment and adoption; medical/psychiatric evaluation; adoptive home evaluation.
NUMBER SERVED	FY 86, 1395 (average monthly caseload)
POTENTIAL POPULATION	Potential population is based on those foster children for whom adoption will become the permanent plan. It is estimated that between 500-1000 children will enter adoption service categories. There has been a 3-10 percent increase in average monthly caseloads of closing cases after adoption with subsidized adoptions increasing at similar levels.
FUNDING	FY 86, $3,900.00
AVAILABILITY	Statewide

SPECIAL EDUCATION PUBLIC SCHOOL — MSDE

SERVICES	Day education in the public school system (Level I-V services)
ELIGIBILITY	A student who has been identified through educational assessments as having an educationally handicapping condition and who needs special education services provided and available in the public school system
WHO PROVIDES	All 24 local education agencies in Maryland
NUMBER SERVED	88,022 students during school year 1984-85 received Level I-V special education services in the public schools of Maryland
POTENTIAL POPULATION	Any child from birth through age 20, identified as educationally handicapped and in need of Level I-V special education services by a local education agency's Admission, Review and Dismissal Commiteee.
FUNDING	FY 84, $255,053,850, local, state and federal education funds; no major increase is anticipated
AVAILABILITY	Services are available to all eligible students enrolled in a public school program in Maryland.

SPECIAL EDUCATION SERVICES — MSDE

SERVICES	Education in nonpublic day school facilities and/or state operated day programs (Level V Services)
ELIGIBILITY	A student, identified through educational assessments as having a handicapping condition, who requires a comprehensive special education setting for the entire school day in a special day school
WHO PROVIDES	Approved nonpublic day schools located in Maryland and state-operated programs in cooperation with local education agencies
NUMBER SERVED	During the 1984-85 school year approximately 1,273 handicapped students received Level V services in a nonpublic day school or state operated program.
POTENTIAL POPULATION	Any child from birth through age 20 who is identified as educationally handicapped and in need of Level V nonpublic special education services by a local education agency's Admission, Review and Dismissal Committee.
FUNDING	FY 84, $9,398,960; no major increase is anticipated
AVAILABILITY	Services are available to all eligible students in Maryland

EDUCATIONAL SERVICES — MSDE

SERVICES	Education in nonpublic residential facilities and/or state operated programs (Level VI Services)
ELIGIBILITY	A student, identified through educational assessments as having an educational handicapping condition, who requires 24 hour special education programming and personal care
WHO PROVIDES	Approved nonpublic residential schools for the handicapped and state-operated residential programs in cooperation with local education agencies
NUMBER SERVED	685 handicapped students served during school year 1984-85 received Level VI services.
POTENTIAL POPULATION	Any child from birth through age 20, who is identified as educationally handicapped and in need of Level VI services by a local education agency's Admission, Review and Dismissal Committee
FUNDING	FY 84, $21,415,851 local and state education funds; no major increase is anticipated
AVAILABILITY	Services are available to all eligible students in Maryland.